MONTANA LEGISLATIVE HISTORY

Chapter 619 19 93

Bill H 622 S _____ Original bill & history X C

H. SELECT Committee on WORKERS' COMPENSATION S. Committee on _____

Hearing Date(s)	2/17	X C	Hearing Date(s)	_____	___C
EXEC. ACTION	3/12	X C		_____	___C
	_____	___C		_____	___C
	_____	___C		_____	___C
Date Out	_____	___C			

Did this bill originate in an interim committee? ____Yes ____No

Committee _____ Report _____

NOTE: HOUSE SELECT COMMITTEE REPORT ON WORKERS' COMPENSATION, DATED 3/13, IS MISSING PAGES 2 & 5 - WE DO NOT HAVE THESE PAGES.

MONTANA LEGISLATIVE HISTORY

Chapter 619 19 93

Bill H 622 S _____ Original bill & history ___C

H. Committee on LABOR & EMPLOYMENT RELATIONS S./ SELECT Committee on WORKERS' COMPENSATION

Hearing Date(s)	3/16	X C	Hearing Date(s)	4/02	X C
EXEC. ACTION	3/18	X C		4/20	X C
	_____	___C		_____	___C
	_____	___C		_____	___C
Date Out	_____	___C			

Did this bill originate in an interim committee? ___Yes ___No

Committee _____ Report _____

	TRANSMITTED TO SENATE		
3/01	FIRST READING		
3/01	REFERRED TO LABOR & EMPLOYMENT RELATIONS		
3/11	HEARING		
3/19	COMMITTEE REPORT—BILL CONCURRED		
3/20	2ND READING CONCURRED	28	11
3/22	3RD READING CONCURRED	38	10
	RETURNED TO HOUSE		
3/24	SIGNED BY SPEAKER		
3/25	SIGNED BY PRESIDENT		
3/25	TRANSMITTED TO GOVERNOR		
3/29	SIGNED BY GOVERNOR		
	CHAPTER NUMBER 224		
	EFFECTIVE DATE: 07/01/94		

HB 622 INTRODUCED BY EWER, ET AL.

GENERALLY REVISE WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE LAWS

2/13	INTRODUCED		
2/13	REFERRED TO HOUSE SELECT COMMITTEE ON WORKERS' COMPENSATION		
2/13	FISCAL NOTE REQUESTED		
2/13	FIRST READING		
2/17	HEARING		
2/20	FISCAL NOTE RECEIVED		
2/22	FISCAL NOTE PRINTED		
3/13	COMMITTEE REPORT—BILL PASSED AS AMENDED AND REREFERRED TO LABOR & EMPLOYMENT RELATIONS		
3/16	HEARING		
3/20	COMMITTEE REPORT—BILL PASSED AS AMENDED		
3/24	2ND READING PASSED	96	2
3/25	3RD READING PASSED	98	0
	TRANSMITTED TO SENATE		
3/26	FIRST READING		
3/26	REFERRED TO SENATE SELECT COMMITTEE ON WORKERS' COMPENSATION		
4/02	HEARING		
4/08	COMMITTEE REPORT—BILL CONCURRED AS AMENDED		
4/12	2ND READING CONCURRED AS AMENDED	47	1
4/13	MOTION CARRIED TO PLACE ON 3RD READING ON 82ND LEGISLATIVE DAY	50	0
4/14	3RD READING CONCURRED	46	3
	RETURNED TO HOUSE WITH AMENDMENTS		
4/15	2ND READING AMENDMENTS NOT CONCURRED	56	44
4/15	FREE CONFERENCE COMMITTEE APPOINTED		
4/21	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/22	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	97	2
4/22	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	98	0
	SENATE		
4/19	FREE CONFERENCE COMMITTEE APPOINTED		
4/21	FREE CONFERENCE COMMITTEE REPORT NO. 1		
4/21	2ND READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	49	0
4/22	3RD READING FREE CONFERENCE COMMITTEE REPORT NO. 1 ADOPTED	48	0

Chapter Page

PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE *2554*

618 *(House Bill No. 453; Molnar)* AN ACT CREATING CIVIL PENALTIES TO BE ASSESSED BY THE DEPARTMENT OF LABOR AND INDUSTRY AGAINST PERSONS CONVICTED OF THEFT FOR WORKERS' COMPENSATION FRAUD; DIRECTING THAT ANY EXCESS MONEY COLLECTED FROM PERSONS CONVICTED OF WORKERS' COMPENSATION FRAUD BE USED TO SUPPORT THE INVESTIGATION AND PROSECUTION OF WORKERS' COMPENSATION FRAUD; AND AMENDING SECTIONS 39-71-316 AND 45-6-301, MCA *2555*

619 *(House Bill No. 622; Ewer)* AN ACT GENERALLY REVISING WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE LAWS; PROVIDING FOR SUSPENSION OF BENEFITS TO A WORKER WHO FAILS TO KEEP MEDICAL APPOINTMENTS; DESIGNATING LIABILITY FOR OCCUPATIONAL DISEASE BENEFITS IF THERE IS MORE THAN ONE INSURER; REVISING BENEFITS WHEN OCCUPATIONAL DISEASE IS AGGRAVATED BY NONCOMPENSABLE DISEASE OR INFIRMITY; CREATING TEMPORARY PARTIAL DISABILITY BENEFITS; REVISING ELIGIBILITY REQUIREMENTS TO SELF-INSURE; ALLOWING CERTAIN OPTIONAL DEDUCTIBLES TO POLICYHOLDERS; REQUIRING SUSPENSION, REVOCATION, OR DENIAL OF A PROFESSIONAL OR OCCUPATIONAL LICENSE FOR VIOLATION OF THE WORKERS' COMPENSATION LAW; REVISING THE DEFINITION OF UNPROFESSIONAL CONDUCT; PROHIBITING CERTAIN ACTIONS; PRECLUDING LIABILITY FOR REPORTING VIOLATIONS OF THE WORKERS' COMPENSATION LAW; ALLOWING AUGMENTATION OF TEMPORARY TOTAL DISABILITY BENEFITS WITH SICK LEAVE AND VACATION LEAVE; REQUIRING THE STATE FUND BOARD TO ADOPT AN ANNUAL BUSINESS PLAN; ALLOWING GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE; REQUIRING THE INSURER TO NOTIFY CLAIMANTS OF BENEFITS AND ENTITLEMENT USING INFORMATION PROVIDED BY THE DEPARTMENT; REQUIRING INSURERS TO NOTIFY EMPLOYERS OF REOPENED CLAIMS; ALLOWING INSURERS TO SUSPEND BENEFITS TO WORKERS RECEIVING SOCIAL SECURITY DISABILITY BENEFITS; AMENDING SECTIONS 37-1-131, 37-3-322, 37-6-310, 37-10-311, 37-12-321, 37-14-321, 39-71-116, 39-71-123, 39-71-307, 39-71-316, 39-71-407, 39-71-601, 39-71-605, 39-71-606, 39-71-607, 39-71-701, 39-71-702, 39-71-736, 39-71-2101, 39-71-2315, AND 39-72-303, MCA; AND PROVIDING AN EFFECTIVE DATE *2558*

620 *(House Bill No. 431; Strizich)* AN ACT REVISING THE BENEFIT PAID TO THE SURVIVING SPOUSE OF CERTAIN MEMBERS OF THE MUNICIPAL POLICE OFFICERS' RETIREMENT SYSTEM; INCREASING EMPLOYER AND EMPLOYEE CONTRIBUTIONS TO FUND THE BENEFIT CHANGE; AMENDING SECTIONS 19-9-601, 19-9-703, 19-9-804, AND 19-9-911, MCA; AND PROVIDING AN IMMEDIATE EFFECTIVE DATE AND A RETROACTIVE APPLICABILITY DATE . . . *2579*

621 *(House Bill No. 530; Spring)* AN ACT ALLOWING THE DEPARTMENT OF TRANSPORTATION TO ISSUE SPECIAL PERMITS FOR CERTAIN TRUCK-TRAILER-TRAILER VEHICLE COMBINATIONS THAT ARE NOT MORE THAN 95 FEET IN LENGTH; AMENDING SECTION 61-10-124, MCA; AND PROVIDING AN EFFECTIVE DATE *2581*

622 *(Senate Bill No. 354; Christiaens)* AN ACT CREATING A CONTINUING EDUCATION FOR INSURERS PROGRAM; PROVIDING THAT THE PROGRAM BE ADMINISTERED BY THE COMMISSIONER OF INSURANCE; GRANTING RULEMAKING AUTHORITY TO CONDUCT

4/28 SIGNED BY SPEAKER
4/28 SIGNED BY PRESIDENT
4/29 TRANSMITTED TO GOVERNOR
5/06 SIGNED BY GOVERNOR
CHAPTER NUMBER 619
EFFECTIVE DATE: 07/01/93

HB 623 INTRODUCED BY GRIMES, ET AL.
REQUIRE RESIDENCY FOR RECEIPT OF GENERAL RELIEF

2/13 INTRODUCED
2/13 REFERRED TO HUMAN SERVICES & AGING
2/13 FISCAL NOTE REQUESTED
2/13 FIRST READING
2/17 HEARING
2/19 FISCAL NOTE RECEIVED
2/19 TABLED IN COMMITTEE
2/19 MOTION FAILED TO TAKE FROM COMMITTEE AND PLACE ON 2ND READING 54 42
(MOTION REQUIRED 3/5 VOTE TO PASS)
2/20 FISCAL NOTE PRINTED

HB 624 INTRODUCED BY COBB, ET AL.
REVISE HUMAN RIGHTS STATUTE OF LIMITATIONS AND PROCEDURE
BY REQUEST OF COMMISSION FOR HUMAN RIGHTS

2/13 INTRODUCED
2/13 REFERRED TO JUDICIARY
2/13 FIRST READING
2/17 HEARING
2/19 TABLED IN COMMITTEE

HB 625 INTRODUCED BY WYATT, ET AL.
ALLOW CREDIT FOR MILITARY SERVICE UNDER PERS

2/13 INTRODUCED
2/13 REFERRED TO STATE ADMINISTRATION
2/13 FIRST READING
2/13 FISCAL NOTE REQUESTED
2/17 HEARING
2/19 FISCAL NOTE RECEIVED
2/19 FISCAL NOTE PRINTED
2/19 TABLED IN COMMITTEE

HB 626 INTRODUCED BY BOHARSKI, ET AL.
CONSTITUTIONAL AMENDMENT TO PLACE LIMIT ON GOVERNMENTAL SPENDING AND TAX COLLECTIONS

2/13 INTRODUCED
2/13 REFERRED TO TAXATION
2/13 FIRST READING
2/17 HEARING
3/12 TABLED IN COMMITTEE

HB 627 INTRODUCED BY T. NELSON
ALLOW TAX DEED HOLDER TO DEMAND QUITCLAIM DEED

2/13 INTRODUCED
2/13 REFERRED TO TAXATION
2/13 FIRST READING
2/17 HEARING

HOUSE BILL NO. 622

INTRODUCED BY EWER, HARP

IN THE HOUSE

FEBRUARY 13, 1993	INTRODUCED AND REFERRED TO SELECT COMMITTEE ON WORKERS' COMPENSATION.
	FIRST READING.
MARCH 13, 1993	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
	ON MOTION, REREFERRED TO COMMITTEE ON LABOR & EMPLOYMENT RELATIONS.
MARCH 20, 1993	COMMITTEE RECOMMEND BILL DO PASS AS AMENDED. REPORT ADOPTED.
MARCH 23, 1993	PRINTING REPORT.
MARCH 24, 1993	SECOND READING, DO PASS.
MARCH 25, 1993	ENGROSSING REPORT.
	THIRD READING, PASSED. AYES, 98; NOES, 0.
	TRANSMITTED TO SENATE.

IN THE SENATE

MARCH 26, 1993	INTRODUCED AND REFERRED TO SELECT COMMITTEE ON WORKERS' COMPENSATION.
	FIRST READING.
APRIL 8, 1993	COMMITTEE RECOMMEND BILL BE CONCURRED IN AS AMENDED. REPORT ADOPTED.
APRIL 12, 1993	SECOND READING, CONCURRED IN AS AMENDED.
APRIL 13, 1993	ON MOTION, TAKEN FROM THIRD READING AND PLACED ON THIRD READING ON 82ND LEGISLATIVE DAY.
APRIL 14, 1993	THIRD READING, CONCURRED IN.

AYES, 46; NOES, 3.

RETURNED TO HOUSE WITH AMENDMENTS.

IN THE HOUSE

APRIL 15, 1993 — SECOND READING, AMENDMENTS NOT CONCURRED IN.

ON MOTION, FREE CONFERENCE COMMITTEE REQUESTED AND APPOINTED.

IN THE SENATE

APRIL 19, 1993 — ON MOTION, FREE CONFERENCE COMMITTEE REQUESTED AND APPOINTED.

APRIL 22, 1993 — FREE CONFERENCE COMMITTEE REPORT ADOPTED.

IN THE HOUSE

APRIL 22, 1993 — SECOND READING, FREE CONFERENCE COMMITTEE REPORT ADOPTED.

THIRD READING, FREE CONFERENCE COMMITTEE REPORT ADOPTED.

APRIL 23, 1993 — SENT TO ENROLLING.

REPORTED CORRECTLY ENROLLED.

House BILL NO. 622

INTRODUCED BY Ewer HARP

A BILL FOR AN ACT ENTITLED: "AN ACT GENERALLY REVISING WORKERS' COMPENSATION AND OCCUPATIONAL DISEASE LAWS; PROVIDING FOR SUSPENSION OF BENEFITS TO A WORKER WHO FAILS TO KEEP MEDICAL APPOINTMENTS; AUTHORIZING SETTLEMENTS FOR FUTURE MEDICAL BENEFITS; REVISING REHABILITATION BENEFITS REQUIREMENTS; DESIGNATING LIABILITY FOR OCCUPATIONAL DISEASE BENEFITS IF THERE IS MORE THAN ONE INSURER; REVISING BENEFITS WHEN OCCUPATIONAL DISEASE IS AGGRAVATED BY NONCOMPENSABLE DISEASE OR INFIRMITY; REQUIRING NONRESIDENT EMPLOYERS TO OBTAIN IN-STATE COVERAGE OR PAY THE DIFFERENCE IN PREMIUMS; PROVIDING FOR FINES FOR EMPLOYER MISCONDUCT; CREATING A MEDICAL PANEL AND PROCEDURES FOR HANDLING PREEXISTING INJURY DISPUTES; CREATING TEMPORARY PARTIAL DISABILITY BENEFITS; REQUIRING EMPLOYERS TO REPORT NEW EMPLOYEES TO THE INSURER AND DEPARTMENT WITHIN 72 HOURS OF THE FIRST PAYDAY AFTER HIRING; REVISING ELIGIBILITY REQUIREMENTS TO SELF-INSURE; AMENDING SECTIONS 39-71-116, 39-71-307, 39-71-407, 39-71-604, 39-71-605, 39-71-607, 39-71-741, 39-71-2001, 39-71-2101, 39-72-303, AND 39-72-706, MCA; AND REPEALING SECTION 39-71-402, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

Section 1. Section 39-71-116, MCA, is amended to read:

"39-71-116. **Definitions.** Unless the context otherwise requires, words and phrases employed in this chapter have the following meanings:

(1) "Administer and pay" includes all actions by the state fund under the Workers' Compensation Act and the Occupational Disease Act of Montana necessary to:

(a) the investigation, review, and settlement of claims;

(b) payment of benefits;

(c) setting of reserves;

(d) furnishing of services and facilities; and

(e) utilization of actuarial, audit, accounting, vocational rehabilitation, and legal services.

(2) "Average weekly wage" means the mean weekly earnings of all employees under covered employment, as defined and established annually by the Montana department of labor and industry. It is established at the nearest whole dollar number and must be adopted by the department prior to July 1 of each year.

(3) "Beneficiary" means:

(a) a surviving spouse living with or legally entitled to be supported by the deceased at the time of injury;

(b) an unmarried child under the age of 18 years;

(c) an unmarried child under the age of 22 years who is

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a full-time student in an accredited school or is enrolled in an accredited apprenticeship program;

(d) an invalid child over the age of 18 years who is dependent upon the decedent for support at the time of injury;

(e) a parent who is dependent upon the decedent for support at the time of the injury if no a beneficiary, as defined in subsections (3)(a) through (3)(d), ~~exists~~ does not exist; and

(f) a brother or sister under the age of 18 years if dependent upon the decedent for support at the time of the injury but only until the age of 18 years and only when no a beneficiary, as defined in subsections (3)(a) through (3)(e), ~~exists~~ does not exist.

(4) "Casual employment" means employment not in the usual course of trade, business, profession, or occupation of the employer.

(5) "Child" includes a posthumous child, a dependent stepchild, and a child legally adopted prior to the injury.

(6) "Construction industry" means the major group of general contractors and operative builders, heavy construction (other than building construction) contractors, and special trade contractors, listed in major groups 15 through 17 in the 1987 Standard Industrial Classification Manual. The term does not include office workers, design

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professionals, ~~salesmen~~ salespersons, estimators, or any other related employment that is not directly involved on a regular basis in the provision of physical labor at a construction or renovation site.

(7) "Days" means calendar days, unless otherwise specified.

(8) "Department" means the department of labor and industry.

(9) "Fiscal year" means the period of time between July 1 and the succeeding June 30.

(10) "Insurer" means an employer bound by compensation plan No. 1, an insurance company transacting business under compensation plan No. 2, the state fund under compensation plan No. 3, or the uninsured employers' fund provided for in part 5 of this chapter.

(11) "Invalid" means one who is physically or mentally incapacitated.

(12) "Maximum healing" means the status reached when a worker is as far restored medically as the permanent character of the work-related injury will permit.

(13) "Order" means any decision, rule, direction, requirement, or standard of the department or any other determination arrived at or decision made by the department.

(14) "Payroll", "annual payroll", or "annual payroll for the preceding year" means the average annual payroll of the

employer for the preceding calendar year or, if the employer ~~shall~~ has not ~~have~~ operated a sufficient or any length of time during ~~such~~ the calendar year, 12 times the average monthly payroll for the current year. However, an estimate may be made by the department for any employer starting in business if ~~no~~ average payrolls are not available. This estimate ~~is to~~ must be adjusted by additional payment by the employer or refund by the department, as the case may actually be, on December 31 of ~~such~~ the current year. An employer's payroll must be computed by calculating all wages, as defined in 39-71-123, that are paid by an employer.

(15) "Permanent partial disability" means a condition, after a worker has reached maximum healing, in which a worker:

(a) has a medically determined physical restriction as a result of an injury as defined in 39-71-119; and

(b) is able to return to work in some capacity but the physical restriction impairs the worker's ability to work.

(16) "Permanent total disability" means a condition resulting from injury as defined in this chapter, after a worker reaches maximum healing, in which a worker ~~has no~~ does not have a reasonable prospect of physically performing regular employment. Regular employment means work on a recurring basis performed for remuneration in a trade,

business, profession, or other occupation in this state. Lack of immediate job openings is not a factor to be considered in determining if a worker is permanently totally disabled.

(17) The term "physician" includes "surgeon" and in either case means one authorized by law to practice ~~his~~ the person's profession in this state.

(18) The "plant of the employer" includes the place of business of a third person while the employer has access to or control over ~~such~~ the place of business for the purpose of carrying on ~~his~~ the employer's usual trade, business, or occupation.

(19) "Public corporation" means the state or any county, municipal corporation, school district, city, city under commission form of government or special charter, town, or village.

(20) "Reasonably safe place to work" means that the place of employment has been made as free from danger to the life or safety of the employee as the nature of the employment will reasonably permit.

(21) "Reasonably safe tools and appliances" are such tools and appliances as are adapted to and are reasonably safe for use for the particular purpose for which they are furnished.

(22) "Temporary partial disability" means a condition

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resulting from an injury as defined in 39-71-119, covering the period after an injured worker returns to work in the same, modified, or alternative employment and before the worker has reached maximum healing.

~~(22)~~(23) "Temporary service contractor" means any person, firm, association, or corporation conducting business that employs individuals directly for the purpose of furnishing the services of those individuals on a part-time or temporary basis to others.

~~(23)~~(24) "Temporary total disability" means a condition resulting from an injury as defined in this chapter that results in total loss of wages and exists until the injured worker reaches maximum healing.

~~(24)~~(25) "Temporary worker" means a worker whose services are furnished to another on a part-time or temporary basis to substitute for a permanent employee on leave or to meet an emergency or short-term workload.

~~(25)~~(26) "Year", unless otherwise specified, means calendar year."

Section 2. Section 39-71-307, MCA, is amended to read:

"**39-71-307. Employers and insurers to file reports of accidents -- penalty.** (1) Every employer and every insurer is required to file with the department, under department rules, a full and complete report of every accident to an employee arising out of or in the course of ~~his~~ employment and resulting in loss of life or injury to the employee. The reports must be furnished to the department in the form and detail as the department prescribes and must provide specific answers to all questions required by the department under its rules. However, if an employer is unable to answer a question, ~~he~~ the employer shall state the reason ~~he--is unable~~ for the employer's inability to answer.

(2) Every insurer transacting business under this chapter shall, at the time and in the manner prescribed by the department, make and file with the department the reports of accidents as the department requires.

(3) An employer, insurer, or adjuster who refuses or neglects to submit to the department reports necessary for the proper filing and review of a claim, as provided in subsection (1), ~~may~~ shall be assessed a penalty of not less than $200 or more than $500 for each offense. The department shall assess and collect the penalty. An insurer may contest a penalty assessment in a hearing conducted according to department rules."

Section 3. Section 39-71-407, MCA, is amended to read:

"**39-71-407. Liability of insurers -- limitations.** (1) Every insurer is liable for the payment of compensation, in the manner and to the extent ~~hereinafter~~ provided in this section, to an employee of an employer it insures who receives an injury arising out of and in the course of ~~his~~

employment or, in the case of ~~his~~ death from ~~such~~ the injury, to ~~his~~ the employee's beneficiaries, if any.

(2) (a) An insurer is liable for an injury as defined in 39-71-119 if the claimant establishes it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that ~~such~~ the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(3) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(a) (i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement; and

(ii) the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(b) the travel is required by the employer as part of the employee's job duties.

(4) An employee is not eligible for benefits otherwise payable under this chapter if ~~the employee's use of alcohol or drugs not prescribed by a physician is the sole and exclusive cause of the injury or death. However, if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply~~ it is medically determined that the employee's use of alcohol or nonprescription drugs was an influencing factor in the cause of the injury or death.

(5) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(6) If a preexisting condition is aggravated by any other condition, disease, or infirmity not itself compensable or if disability or death from any other cause not itself compensable is aggravated, prolonged, accelerated, or in any way contributed to by an injury as defined in 39-71-119, the compensation and medical benefits payable under this chapter must be reduced and limited to the proportion of the disability or death resulting from the injury.

(7) If a claimant's compensation is proportionally reduced as provided in subsection (6) and the claimant receives social security disability benefits, any offset that an insurer may be entitled to must be reduced in the

same proportion as the claimant's compensation was reduced for as long as the claimant receives the social security disability benefits."

Section 4. Section 39-71-604, MCA, is amended to read:

"39-71-604. Application for compensation. (1) If a worker is entitled to benefits under this chapter, the worker shall file with the insurer all reasonable information needed by the insurer to determine compensability. It is the duty of the worker's attending physician to lend all necessary assistance in making application for compensation and such the proof of other matters as may be required by the rules of the department without charge to the worker. The filing of forms or other documentation by the attending physician does not constitute a claim for compensation.

(2) Workers applying for compensation for an injury or occupational disease shall allow the insurer or the insurer's designated agent direct access to medical service providers, medical information, and the injured worker. Failure to comply with this subsection will result in termination of benefits.

~~(2)~~(3) If death results from an injury, the parties entitled to compensation or someone in their behalf shall file a claim with the insurer. The claim must be accompanied with proof of death and proof of relationship, showing the

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parties entitled to compensation, certificate of the attending physician, if any, and such other proof as may be required by the department."

Section 5. Section 39-71-605, MCA, is amended to read:

"39-71-605. Examination of employee by physician -- effect of refusal to submit to examination -- report and testimony of physician -- cost. (1) (a) Whenever in case of injury the right to compensation under this chapter would exist in favor of any employee, he the employee shall, upon the written request of the insurer, submit from time to time to examination by a physician or panel of physicians, who ~~shall~~ must be provided and paid for by such the insurer, and shall likewise submit to examination from time to time by any physician or panel of physicians selected by the department.

(b) The request or order for such an examination ~~shall~~ must fix a time and place for the examination, with regard for the employee's convenience, ~~his~~ physical condition, and ~~his~~ ability to attend at the time and place that is as close to the employee's residence as is practical. The employee ~~shall be~~ is entitled to have a physician present at any such examination. ~~So long as~~ If the employee, after such written request, ~~shall fail~~ fails or ~~refuse~~ refuses to submit to such the examination or ~~shall~~ in any way ~~obstruct~~ obstructs the same examination, ~~his~~ the employee's right to

compensation ~~shall~~ must be suspended and is subject to the provisions of 39-71-607. Any physician or panel of physicians employed by the insurer or the department who ~~shall make~~ makes or be is present at any ~~such~~ examination may be required to testify as to the results ~~thereof~~ of the examination.

(2) In the event of a dispute concerning the physical condition of a claimant or the cause or causes of the injury or disability, if any, the department, at the request of the claimant or insurer, as the case may be, shall require the claimant to submit to ~~such~~ an examination as it ~~may--deem~~ considers desirable by a physician or panel of physicians within the state or elsewhere who have had adequate and substantial experience in the particular field of medicine concerned with the matters presented by the dispute. The physician or panel of physicians making the examination shall file a written report of findings with the claimant and insurer for their use in the determination of the controversy involved. The requesting party shall pay the physician or panel of physicians for the examination.

(3) This section does not apply to impairment evaluations provided for in 39-71-711."

Section 6. Section 39-71-607, MCA, is amended to read:

"**39-71-607. Suspension of payments by insurer up to thirty days pending receipt of medical information.** Under

rules adopted by the department ~~and in the discretion of the department~~, an insurer may suspend compensation payments for not more than 30 days pending the receipt of medical information when an injured worker unreasonably fails to keep scheduled medical appointments. If, after a medical examination, the injured worker is released to return to work, the worker forfeits the right to any suspended benefits."

Section 7. Section 39-71-741, MCA, is amended to read:

"**39-71-741. Compromise settlements and lump-sum payments.** (1) (a) Benefits may be converted in whole to a lump sum:

(i) if a claimant and an insurer dispute the initial compensability of an injury; and

(ii) if the claimant and insurer agree to a settlement.

(b) The agreement is subject to department approval. The department may disapprove an agreement under this section only if there is not a reasonable dispute over compensability.

(c) Upon approval, the agreement constitutes a compromise and release settlement and may not be reopened by the department.

(2) (a) If an insurer has accepted initial liability for an injury, permanent partial disability benefits may be converted in whole or in part to a lump-sum payment.

(b) The total of any lump-sum conversion in part that is awarded to a claimant prior to the claimant's final award may not exceed the anticipated award under 39-71-703 or $20,000, whichever is less.

(c) An agreement is subject to department approval. The department may disapprove an agreement only if the department determines that the settlement amount is inadequate. If disapproved, the department shall set forth in detail the reasons for disapproval.

(d) Upon approval, the agreement constitutes a compromise and release settlement and may not be reopened by the department.

(3) Permanent total disability benefits may be converted in whole or in part to a lump sum. The total of all lump-sum conversions in part that are awarded to a claimant may not exceed $20,000. A conversion may be made only upon the written application of the injured worker with the concurrence of the insurer. Approval of the lump-sum payment rests in the discretion of the department. The approval or award of a lump-sum payment by the department or court must be the exception. It may be given only if the worker has demonstrated financial need that:

(a) relates to:

(i) the necessities of life;

(ii) an accumulation of debt incurred prior to the injury; or

(iii) a self-employment venture that is considered feasible under criteria set forth by the department; or

(b) arises subsequent to the date of injury or arises because of reduced income as a result of the injury.

(4) Any lump-sum conversion of benefits under subsection (3) must be converted to present value using the rate prescribed under subsection (5)(b).

(5) (a) An insurer may recoup any lump-sum payment amortized at the rate established by the department, prorated biweekly over the projected duration of the compensation period.

(b) The rate adopted by the department must be based on the average rate for United States 10-year treasury bills in the previous calendar year, rounded to the nearest whole number.

(c) If the projected compensation period is the claimant's lifetime, the life expectancy must be determined by using the most recent table of life expectancy as published by the United States national center for health statistics.

(6) Subject to the other provisions of this section, the department has full power, authority, and jurisdiction to allow, approve, or condition compromise settlements for any type of benefits provided for under this chapter,

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including the right to future medical benefits, or for lump-sum payments agreed to by workers and insurers. All such compromise settlements and lump-sum payments are void without the approval of the department. Approval by the department must be in writing. The department shall directly notify a claimant of a department order approving or denying a claimant's compromise or lump-sum payment.

(7) A dispute between a claimant and an insurer regarding the conversion of biweekly payments into a lump-sum is considered a dispute, for which a mediator and the workers' compensation court have jurisdiction to make a determination. If an insurer and a claimant agree to a compromise and release settlement or a lump-sum payment but the department disapproves the agreement, the parties may request the workers' compensation court to review the department's decision.

(8) An injured worker's entitlement to future medical benefits may be terminated by mutual consent of the worker and the insurer, subject to department approval. The department may not disapprove an agreement unless it determines that the worker has not been fully compensated for terminating the worker's right to future medical benefits."

Section 8. Section 39-71-2001, MCA, is amended to read:

"**39-71-2001. Rehabilitation benefits.** (1) An injured

worker is eligible for rehabilitation benefits if:

(a) the injury results in permanent partial disability or permanent total disability as defined in 39-71-116;

(b) a physician certifies that the injured worker is physically unable to work at the job the worker held at the time of the injury;

(c) a rehabilitation plan completed by a rehabilitation provider and designated by the insurer certifies that the injured worker has reasonable vocational goals and a reemployment and wage potential with rehabilitation. The plan must take into consideration the worker's age, education, training, work history, residual physical capacities, and vocational interests.

(d) a rehabilitation plan between the injured worker and the insurer is filed with the department. If the plan calls for the expenditure of funds under 39-71-1004, the department shall authorize the department of social and rehabilitation services to use the funds.

(2) After filing the rehabilitation plan with the department, the injured worker is entitled to receive rehabilitation benefits at the injured worker's temporary total disability rate. The benefits must be paid for the period specified in the rehabilitation plan, not to exceed 104 weeks. Rehabilitation benefits must be paid during a reasonable period, not to exceed 10 weeks, while the worker

is waiting to begin the agreed-upon rehabilitation plan. Rehabilitation benefits must be paid while the worker is satisfactorily completing the agreed-upon rehabilitation plan.

(3) If the rehabilitation plan provides for job placement, a vocational rehabilitation provider shall assist the worker in obtaining other employment and the worker is entitled to weekly benefits for a period not to exceed 8 weeks at the worker's temporary total disability rate. If, after receiving benefits under this subsection, the worker decides to proceed with a rehabilitation plan, the weeks in which benefits were paid under this subsection may not be credited against the maximum of 104 weeks of rehabilitation benefits provided in this section.

(4) If there is a dispute as to whether an injured worker can return to the job the worker held at the time of injury, the insurer shall designate a rehabilitation provider to evaluate and determine whether the worker can return to the job held at the time of injury. If it is determined that he the worker cannot return to the job, the worker is entitled to rehabilitation benefits and services as provided in subsection (2).

(5) A worker may not receive temporary total or biweekly permanent partial disability benefits and rehabilitation benefits during the same period of time.

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(6) The rehabilitation provider, as authorized by the insurer, shall continue to work with and assist the injured worker until the rehabilitation plan is completed.

(7) Upon receipt of notification of acceptance of a claim by an insurer, the department shall notify the claimant in writing of potential benefits and entitlements pursuant to 39-71-1014, 39-71-1025, 39-71-1032, and this section.

(8) The rehabilitation benefits referred to in this section are applicable only with the actual provision of the services and may not be negotiated as aspects of a settlement.

(9) Rehabilitation benefits under this section must be elected within 12 months of the date of maximum medical improvement or they are forfeited."

Section 9. Section 39-72-303, MCA, is amended to read:

"39-72-303. Which employer liable. (1) Where compensation is payable for an occupational disease, the only employer liable ~~shall--~~be is the employer in whose employment the employee was last injuriously exposed to the hazard of ~~such~~ the disease.

(2) When there is more than one insurer and only one employer at the time the employee was injuriously exposed to the hazard of the disease, the liability rests with the insurer providing coverage at the earlier of:

(a) the time the occupational disease was first diagnosed by an attending physician, consulting physician, or medical panel; or

(b) the time the employee knew or should have known that the condition was the result of an occupational disease.

~~(2)~~(3) In the case of pneumoconiosis, any coal mine operator who has acquired a mine in the state or substantially all of the assets ~~thereof~~ of a mine from a person who was an operator of ~~such~~ the mine on or after December 30, 1969, is liable for and ~~must~~ shall secure the payment of all benefits ~~which~~ that would have been payable by that person with respect to miners previously employed in ~~such~~ the mine if acquisition had not occurred and that person had continued to operate ~~such~~ the mine, and the prior operator of ~~such~~ the mine ~~shall~~ is not be relieved of any liability under this section."

Section 10. Section 39-72-706, MCA, is amended to read:

"**39-72-706. Aggravation.** (1) If an occupational disease is aggravated by any other disease or infirmity not itself compensable or if disability or death from any other cause not itself compensable is aggravated, prolonged, accelerated, or in any way contributed to by an occupational disease, the compensation and medical benefits payable under this chapter must be reduced and limited to ~~such~~ the

proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death ~~as--such--occupational--disease--as-a causative-factor-bears-to-all-the-causes-of-such--disability or-death~~.

(2) If compensation is reduced a proportionate amount as provided in subsection (1) and the worker receives disability social security benefits, the offset entitlement granted to the insurer must be reduced in the same proportionate amount as the compensation and medical benefits as long as the worker continues to receive disability social security benefits."

NEW SECTION. **Section 11. Requirement of state coverage for nonresident employers.** (1) Beginning July 1, 1993, nonresident employers shall provide workers' compensation coverage under plan No. 1, 2, or 3 or, in the alternative, shall deposit with the department a nonrefundable amount of money equal to the difference between the premium paid out-of-state by the nonresident and the premium the nonresident would pay in Montana if the premium in Montana is higher than the out-of-state premium rate.

(2) Beginning July 1, 1993, a nonresident employer shall verify with the department, prior to commencing to do business in this state, that the nonresident employer has obtained workers' compensation under one of this state's

coverage plans or shall deposit any money due pursuant to subsection (1). The department may monitor the activities of a nonresident employer on a regular basis to ensure that proper coverage is in effect.

(3) The department shall deposit the money collected pursuant to subsection (1) in the uninsured employers' fund provided for in 39-71-502.

NEW SECTION. **Section 12. Employer misconduct.** The department shall fine an employer convicted under 45-7-501 an amount equal to ten times any amount that the department determines the employer wrongfully withheld in not obtaining workers' compensation coverage or in not obtaining the proper workers' compensation coverage. The department shall deposit the money collected pursuant to this section in the uninsured employers' account provided for in 39-71-502.

NEW SECTION. **Section 13. Medical panel for preexisting conditions.** (1) The department shall create a list of physicians to serve on an industrial injury medical panel. The physicians must be nominated by the board of medical examiners and must be certified or eligible for certification in a specialty relevant to the medical issue to be examined by the panel pursuant to this section.

(2) If a dispute exists between a claimant and an employer regarding the extent of liability for the aggravation of a preexisting condition as the result of an

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injury and a settlement cannot be reached, the following procedure must be followed:

(a) The department shall direct the claimant to a member of the medical panel for examination. The panel member must be provided with all relevant medical records, including the findings of independent medical examinations. The panel member shall determine as a percentage the amount of apportionment, if any, assignable to any other noncompensable disease, condition, or infirmity. The department shall forward a copy of the report to the claimant and employer. The party requesting the examination shall pay for the cost of the examination.

(b) Either party may, within 20 days of receipt of the report and at the party's expense, request that the claimant be examined by a second panel member to be selected by the department. The second panel member shall conduct an examination of the claimant and submit a report regarding apportionment with respect to any preexisting condition. The department shall forward copies of the report to the parties.

(c) If a second report is requested, the department shall appoint a third panel member and the two reporting members to review the two reports and to issue a report establishing the amount of apportionment to be assigned to any preexisting condition. The three panel members may

consult with the claimant's attending physician or any independent medical examiner.

(d) If a second examination is not requested, the department shall issue its order determining the percentage of apportionment assigned to any other noncompensable disease, condition, or infirmity, based on the report of the first examining panel member. If a second examination is requested, the department shall base its order on the report of the three panel members. The report of the three members is prima facie evidence of the matters contained in the report.

NEW SECTION. **Section 14.** **Temporary partial disability benefits.** (1) If, prior to maximum healing, an injured worker is medically approved to return to the same, modified, or alternative employment that the worker is able and qualified to perform and the worker suffers an actual wage loss as a result of a temporary work restriction, the worker qualifies for temporary partial disability benefits.

(2) Weekly compensation benefits for temporary partial disability must be the difference between the injured worker's hourly wage received at the time of the injury, subject to a maximum of 40 hours a week, and the actual weekly wages earned during the period that the claimant is temporarily partially disabled.

(3) Temporary partial disability benefits are limited

to a total of 26 weeks of combined weekly compensation or are payable until the time the worker is no longer temporarily partially disabled, whichever occurs first.

(4) The amount of temporary partial disability benefits must be based upon payroll records provided by the employer and calculated on a biweekly basis. The combined wages and compensation benefits may not exceed the worker's average weekly wage at the time of injury.

(5) Temporary partial disability may not be considered an element of permanent partial disability and may not be credited against any permanent impairment or any permanent partial disability award or settlement achieved after the injured worker reaches maximum healing.

NEW SECTION. **Section 15.** **Reporting new employees.** Any employer operating in this state shall report any new employees hired to work in this state and the work classification of those employees to the employer's insurer and the department within 72 hours of the first regularly scheduled payday after hiring the employee.

Section 16. Section 39-71-2101, MCA, is amended to read:

"39-71-2101. General requirements for electing coverage under plan. (1) An employer may elect to be bound by compensation plan No. 1 upon furnishing satisfactory proof to the department and the Montana self-insurers guaranty

fund of ~~his~~ solvency and financial ability to pay the compensation and benefits provided for in this chapter ~~provided for~~ and to discharge all liabilities ~~which~~ that are reasonably likely to be incurred ~~by him~~ during the fiscal year for which ~~such~~ the election is effective. ~~and~~ The employer may, by order of the department and with the concurrence of the guaranty fund, make ~~such~~ the payments directly to ~~his~~ employees as they ~~may~~ become entitled to receive payments under the terms and conditions of this chapter.

(2) Employers who comply with the provisions of this chapter and who are participating in collectively bargained, jointly administered Taft-Hartley trust funds are eligible to provide self-insured workers' compensation benefits for their employees."

NEW SECTION. **Section 17.** Repealer. Section 39-71-402, MCA, is repealed.

NEW SECTION. **Section 18.** Codification instruction. (1) [Sections 11, 12, and 15] are intended to be codified as an integral part of Title 39, chapter 71, part 3, and the provisions of Title 39, chapter 71, part 3, apply to [sections 11, 12, and 15].

(2) [Sections 13 and 14] are intended to be codified as an integral part of Title 39, chapter 71, part 7, and the provisions of Title 39, chapter 71, part 7, apply to [sections 13 and 14].

-End-

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- BILL NO - REFERRED - HEARING - OTHER CONSIDERATION DATES - EXECUTIVE ACTION/DATE/VOTE ------- REREFERRED ---- DATE READ

HB0534	COCCHIARELLA, VICKI		RATES & RATING PLANS BE DEVELOPED WITHOUT REGARD TO MEDICAL DEDUCTIBLE PAID			
	2/09	2/15	DO PASS 2/15 VOTE: 5-0			2/18
HB0587	HARPER, HAL		REVISE WORK COMP CLASSIFICATION AND RATING COMMITTEE PROVISIONS			
	2/10	2/15	PASS AS AMENDED 3/10 VOTE: 6-0		LABOR & EMPLOYMENT	3/11
HB0604	JOHNSON, ROYAL		REVISE WORK COMP - RISK POOL - EMPLOYER/EMPLOYEE PAYROLL TAX - RATE INCREASE			
	2/12	2/15	TABLED ON 03/05 VOTE: 5-0			
HB0622	EWER, DAVID		GENERALLY REVISE WORK COMP AND OCCUPATIONAL DISEASE LAWS			
	2/13	2/17	PASS AS AMENDED 3/12 VOTE: 6-0		LABOR & EMPLOYMENT	3/13
HB0628	TOOLE, HOWARD		CARE MANAGEMENT/BUDGETING FOR WORK COMP; CREATE MEDICAL PROCEDURES AUTH. COM			
	2/13	2/17	PASS AS AMENDED 3/10 VOTE: 4-2		LABOR & EMPLOYMENT	3/11
HB0672	HIBBARD, CHASE		REVISE WORK COMP PAYROLL TAX AND BONDING PROVISIONS			
	3/11		PASS AS AMENDED 3/12 VOTE: 6-0			3/13
HB0686	DRISCOLL, JERRY		EXPAND WORKERS' COMPENSATION PAYROLL TAX BASE			
			FAILED VOTE: 3-3			
SB0163	HARP, JOHN		CREATE SAFETY CULTURE ACT REQUIRING EMPLOYERS ESTABLISH SAFETY PROGRAMS			
	2/23	3/03	CONCUR VOTE: VOICE		LABOR & EMPLOYMENT	3/11
SB0164	HARP, JOHN		CREATE FRAUD INVESTIGATION OFFICE IN DEPT OF JUSTICE & PREVENTION IN ST FUND			
	2/23	3/05	CONCUR VOTE: VOICE		LABOR & EMPLOYMENT	3/11
SB0258	HARP, JOHN		CLARIFY WORKERS' COMPENSATION SUBROGATION RIGHTS			
	2/23	3/05	CONCUR AS AMENDED 3/8 VOTE: 6-0			3/11
SB0347	HARP, JOHN		GENERAL REVISION WORK COMP -- MEDICAL COST CONTAINMENT			
	2/24	3/10	CONCUR AS AMENDED 3/10 VOTE: 6-0		LABOR & EMPLOYMENT	3/11
SB0394	HARP, JOHN		REGULATE ATTORNEY FEES FOR WORKERS' COMPENSATION CASES			
	3/01	3/08	CONCUR AS AMENDED 3/10 VOTE: 4-2		LABOR & EMPLOYMENT	3/11

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By **CHAIRMAN CHASE HIBBARD**, on February 17, 1993, at 3:30 P.M.

ROLL CALL

Members Present:
Rep. Chase Hibbard, Chairman (R)
Rep. Jerry Driscoll, Vice Chairman (D)
Rep. Steve Benedict (R)
Rep. Ernest Bergsagel (R)
Rep. Vicki Cocchiarella (D)
Rep. David Ewer (D)

Members Excused: None

Members Absent: None

Staff Present: Paul Verdon, Legislative Council
Evy Hendrickson, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: HB 628, HB 622
Executive Action: HB 511, HB 455 (Postponed)

HEARING ON HB 622

Opening Statement by Sponsor:

REP. HOWARD TOOLE, House District 60, Missoula, presented HB 628 as a bill that addresses managed care and ratemaking. **REP. TOOLE** said he developed this bill with the help of **George Wood.** He said managed care should be delegated to the medical community and should be negotiated through a planning process that involves workers' comp insurers, claimants and care providers.

Proponents' Testimony:

Mike Micone, representing the **Montana Motor Carriers Association,** said he particularly supported the managed care portion and the planning that went into this bill.

Pat Sweeney, representing the **State Fund,** reiterated **Mr. Micone's**

comments with regard to managed care. He recommended that the committee not act on this bill until **SEN. HARP'S** bill is heard in order that the two bills can be incorporated. He said in section 7 of the bill dealing with NCCI rates these rates would be punitive to a number of industries the State Fund insures. It didn't take into consideration the lower operating costs of the State Fund in comparison to NCCI rates and didn't allow for deviation. He suggested that the State Fund provide the committee with some statistical information with regard to what NCCI rates would do to State Fund policyholders and leave the decision with the committee.

CHAIRMAN HIBBARD asked **Mr. Sweeney** to provide that information to the committee.

Jan VanRiper said she was generally in support of the bill as it provided a balanced approach to medical cost containment. She noted two concerns on page 3, lines 14 through 19: it would be left to the discretion of the insurer whether or not to arrive at a plan to provide any more medical treatment beyond that. **Ms. VanRiper** said, if that was the case, she didn't know the rationale behind discontinuing treatment at maximum medical. The other provision she was concerned with was the freedom of choice provision. It gives the claimant the right to choose a treating physician but, on the other hand, it took that right away by allowing the insurance company to come in under a number of circumstances and disallow that treating physician.

Ms. VanRiper suggested if the claimant must have insurance company approval before he or she does anything, there should also be a requirement that the claimant be notified by the insurance company immediately because there may be medical bills to be paid if the insurance company will not pay.

Don Judge of the Montana State AFL-CIO echoed some of the same concerns of **Ms. VanRiper.**

Mr. Judge said their stance on the choice of physicians was that there should be a procedure for either party to seek a change in the treating physician. Such change should be limited to those incidents where there is legitimate concern over quality and appropriateness of care. Unlimited change of physicians, frequently described as doctor shopping, should not be permitted. This is not intended to restrict referral to suitable specialists or other necessary providers of medical care.

Mr. Judge said managed care organizations have a place in workers' compensation and should be encouraged under the law. There should be a flexible process which provides an opportunity for employees to be involved in the selection of the managed care organization. If there is such a process, the employee's choice of a physician should be limited to physicians who are members of the managed care organization. Appropriate certification and monitoring of such managed care organizations should be the

responsibility of the state agency. **Mr. Judge** said those items should be incorporated into this legislation, and they weren't convinced that they are.

Bill Conner, representing the **Coalition for Workers' Compensation System Improvement,** echoed the statements made by the other proponents although they did not agree with some parts of the proposed bill. He said if a person has greater than 10% impairment, this limits a number of the cases where an individual is on time loss but does not have a 10% impairment rating. He said 30 days is not time enough to determine what the impairment will be. If, after 30 days, chances are when the claim is closed the doctor will be hesitant to give them less than a 10% impairment rating.

Mr. Conner said the majority of the claims that are time loss have no impairment, or they have less than 10% impairment, so most of them wouldn't be covered under this managed care.

Bonnie Tippy, representing the **Montana Chiropractic Association,** said the whole issue of preferred providers in managed care is extremely difficult. This bill gets at the root of the problem of the multiple injured severe cases and those people should go to managed care. It is a compromise between what the insurers want and what the providers want.

Mona Jamison, representing the **Montana Chapter of the American Physical Therapy Association,** strongly supported this bill. She said they would like to work with the committee on the 10% impairment level. That may be very difficult for physicians to determine and she hoped the executive committee would find other ways of addressing this. **Ms. Jamison** also asked that the committee consider allowing the patient to see their provider for the first 30 days and then enter the managed care system.

George Wood, representing the **Montana Self Insurers Association,** said they supported the bill in concept. The managed care provisions of this bill are more in line with what is considered managed care nationally. **Mr. Wood** said the mandatory aspects make it difficult; the other bill discussed confuses managed care providers by putting managed care in the provider system.

Jacqueline Lenmark, representing the **American Insurance Association,** reiterated testimony in support of the bill.

<u>Opponents' Testimony</u>: None

<u>Questions From Committee Members and Responses</u>:

REP. DRISCOLL asked **REP. TOOLE** if he had any objections to an amendment that would prohibit the medical caseworker, such as physicians, from referring within their own clinic if they had a

monetary interest in that clinic. **REP. TOOLE** responded that he would have no objection.

REP. DRISCOLL said there was nothing in the bill that said they couldn't contract out. **REP. TOOLE** said they are not forbidden from doing so, but he did not think they would be doing that. He wanted someone concerned that the medical community was going to run the bill up too high.

REP. BENEDICT asked **Bill Conner** if his group had a position on adopting NCCI rates with no deviation until such time that the actuary says there is enough money to start giving dividends back. **Mr. Conner** said they have not discussed that particular item in this bill. Because they are a coalition, he would have to talk to the members before there would be any decisions made.

REP. COCCHIARELLA asked **REP. TOOLE** to refer to Section 3 where it states "to develop and maintain an authorized medical procedure manual." She asked what the incentive would be for any of these people earning large salaries to serve as volunteers on this committee. Would there be any pay and why would they want to do this? To **REP. COCCHIARELLA** this appeared as a time-consuming project. **REP. TOOLE** said that, from a practical standpoint, there probably has got to be a commitment to it.

REP. COCCHIARELLA asked **Pat Sweeney** the same question. He said the manuals that **REP. TOOLE** speaks of are not manuals per se; they are not something that has been put together with physicians. He said the State Fund has fee schedules. **Mr. Sweeney** said they do consult with their staff physicians as to what treatment plan should take place.

REP. COCCHIARELLA asked **Mr. Sweeney** if this would be a full-time job and would it be a paid staff person that would coordinate and make this work. **Mr. Sweeney** said for the first year, but he didn't think it would be a paid position.

REP. BENEDICT asked **REP. TOOLE** if the bill called for budget protocol and who would police it and determine compliance. **REP. TOOLE** said the bill contemplates that the plan will be developed by the insurer and it would be in the insurer's interest to have it in place to control costs. **REP. TOOLE** said as the bill was written, it was a document between the insurer and the claimant and anyone helping the claimant.

CHAIRMAN HIBBARD asked **REP. TOOLE** if any other states had a managed care system like that being contemplated in this bill. **REP. TOOLE** said he did not know whether states had implemented this type of program, but there were efforts taking place to develop this kind of protocol for medical care and development of a treatment plan per claimant.

CHAIRMAN HIBBARD noted that section 3 states that committee members must be selected by the Governor. He asked **REP. TOOLE** if

another selection process was considered. **REP. TOOLE** said he didn't have any views on that but believed the expertise and the ability to get a quality product was the most important consideration.

Closing by Sponsor:

REP. TOOLE said there were some concepts that might need to be reworked in the bill, but the essence was something he hoped would be part of the final product. Managed care is something that could be done through interaction between the insured, the claimant and the claimant's treating physician. It has to be a system that implements a plan and a budget. A modest claim should not have a full budget or a full plan created. A serious injury would have to be set into a plan to fast track the injured person back to work and to finish up the claim. Managed care could be imposed on existing cases as well as those occurring in the future. It would not be unconstitutional to set simple budgetary systems and managed care plans for cases where the injury had already occurred. He attempted, with this bill, to find a way to plan for the amount of dollars that the individual claim is going to require without infringing on the claimant's ability to receive the full benefits to which he is entitled. This bill has that potential. This proposal would establish a benchmark for ratemaking.

HEARING ON HB 622

Opening Statement by Sponsor:

REP. DAVID EWER, House District 45, Helena, presented the bill on behalf of the Coalition. He reviewed the bill section by section and said he would have an amendment. He believed there should be more board members. He didn't know of any businesses of $100 million plus a year with only five board members; he would be proposing seven board members. He also said he was going to include in the amendment a composition of board members to meet monthly and be paid $12,000 a year plus per diem.

Proponents' Testimony:

Don Allen, Coalition of Workers' Comp System Improvement, expressed the Coalition's appreciation to **REP. EWER** for introducing this bill. He said the Coalition had four committees working over a period of three months: on law, safety, administration and medical. This bill attempts to address issues not included in other bills presented.

Bill Conner with the **Coalition** said the bill was a compromise of some issues the Coalition saw as some problems with existing work

comp law. He highlighted some of the changes proposed in the and reviewed the bill section by section.

Harlee Thompson, Manager of Intermountain Truss in Helena, gave his testimony and urged a do pass. **EXHIBIT 1**

Jim Murphy representing the **State Fund,** said he was a proponent/opponent because there were a number of things to discuss; he referred to the temporary partial disability section.

CHAIRMAN HIBBARD asked **Mr. Murphy** to submit his changes in amendment form. **Mr. Murphy** said he would like to work with everyone on this bill. **CHAIRMAN HIBBARD** also asked **Mr. Conner** to submit his changes in writing as soon as possible.

Bill Crivello, Legislative Representative for the Rehabilitation Association in Montana, and **Branch Manager of Crawford Health and Rehabilitation,** referred to page 11, line 16. **EXHIBIT 2** He said the reality was there are nurses in Montana working on workers' comp cases on behalf of insurers. His firm and several others have nurses trying to work with insurers to move cases. **Mr. Crivello** said he has worked with the task force on recommendations and with the coalition in formulating language such as that on page 11. The intent of this language is to allow medical providers, nurses particularly, who are doing much the same thing as vocational providers in the rehabilitation return-to-work process, to meet with the injured worker and/or physical therapists or physicians to move the case forward.

He asked that the committee pay particular attention as they work on modifying this bill and the managed care bill to protect the right of the insurers to designate somebody other than a vocational person to help move the process forward.

Oliver Goe, representing **MMIA, MSGIA & MACO,** addressed the concept of temporary, partial disability as defined in page 6 of the bill, starting on line 25 and also covered in section 14 of the bill. He said part of the success of the programs of self insurers has been the early return-to-work programs even if they are modified positions. They work with the doctors and rehabilitation programs. To make these programs a success, benefits of some kind must be paid. If the person can only work 20 hours a week, they make up the difference.

Mr. Goe referred to page 10 on the use of alcohol and had a problem with the term "medically."

George Wood, representing the **Self Insurers Association,** said there were so many amendments that this should be a gray bill because that would be the only way to make sense out of all the amendments. He echoed what **Mr. Goe** said about the temporary, partial. He said the self insurers have been using that for years and have been uncomfortable with the fact that they were paying benefits not required in the law. **Mr. Wood** said the

incentive would be the best therapy for the employee to have an early return to work.

Opponents' Testimony:

Don Judge, representing the **Montana State AFL-CIO,** said he had some concerns with the lack of incentives by changing the statutes. He referred to page 10 line 2 through 5 and didn't think that should be deleted in HB 622.

Norm Grosfield, Attorney from **Helena,** said he was involved in workers' compensation litigation. He said there were some good provisions in the bill. He submitted amendments. **EXHIBITS 3 and 4**

Mike Micone, representing the **Montana Motor Carriers' Association,** stated there are some good ideas in the bill but the bill is too broad and too encompassing. **Mr. Micone** believed that the task was too great to deal with in this particular piece of legislation.

Questions From Committee Members and Responses:

REP. DRISCOLL had several questions concerning the occupational disease portion of the bill and particularly in the instance of medical benefits being prorated with industrial disease in Section 10.

REP. TOOLE said the bill was entirely different when it was drafted and there would be an amendment proposed. There needs to be a determination of liability in the case of occupational disease, particularly when the worker has been with the same employer but there have been different insurers. There has always been a problem of determining the date of the disease. The date of the occupational disease is the date of the diagnosis. In that way, an assignment of liability can be made.

Closing by Sponsor:

REP. BENEDICT closed for **REP. EWER** and said he was asked to convey to the committee and to the people attending that he was aware of the fact that technical changes and minor clerical changes need to be made to the bill. He believed the bill was a very necessary bill and the problems need to be worked out.

CHAIRMAN HIBBARD said the executive session would be postponed on HB 511 and HB 455.

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL DATE 2-17-93

NAME	PRESENT	ABSENT	EXCUSED
CHASE HIBBARD, CHAIRMAN	✓		
JERRY DRISCOLL, VICE CHAIRMAN	✓		
STEVE BENEDICT	✓		
ERNEST BERGSAGEL	✓		
VICKI COCCHIARELLA	✓		
DAVID EWER	✓		

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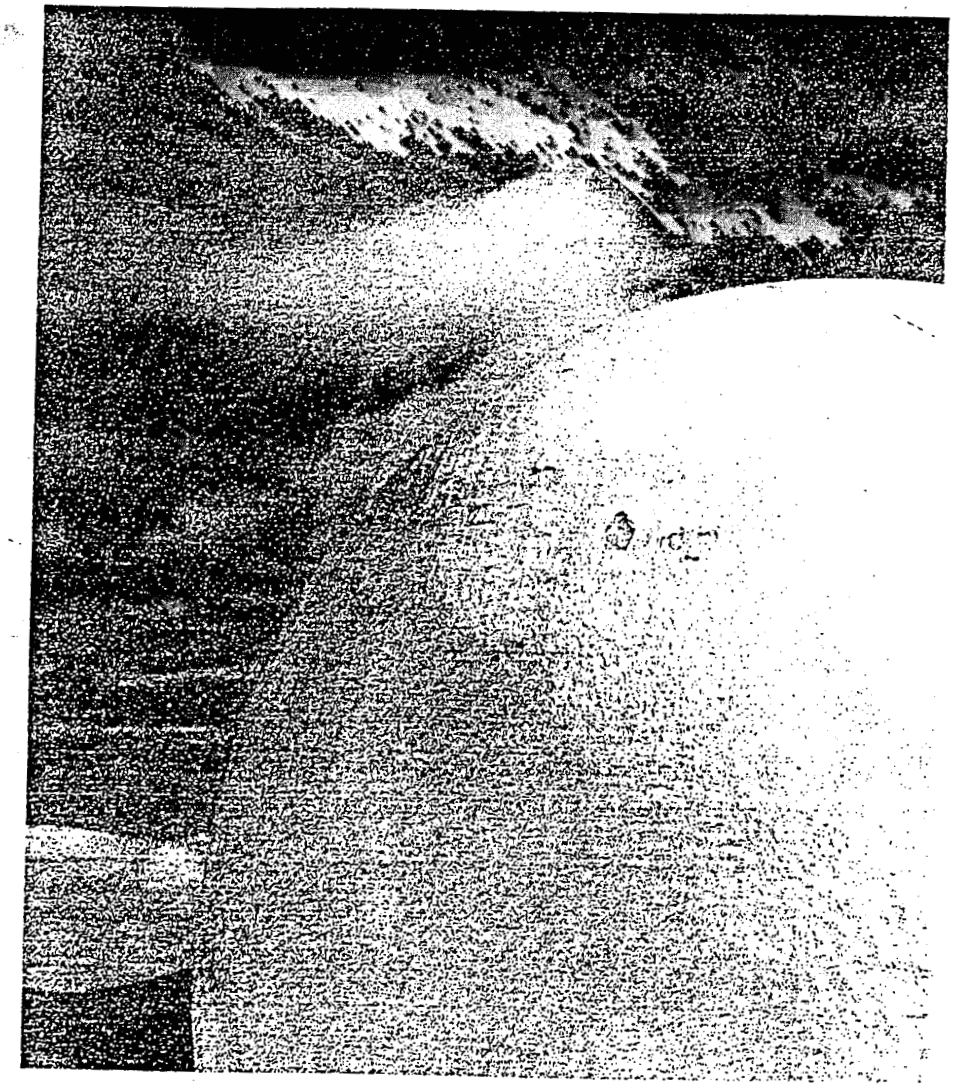
House Select Committee on Workers' Compensati

EXHIBIT
DATE 2-17-93

C E N T R E R E I N S U R A N C E

The original is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.



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A N N U A L

R E P O R T

mebuilders Assoc. of Billings
52-7533

W. Montana Home Builders Assoc.
5-8181

reat Falls Homebuilders Assoc.
52-HOME

Montana BUILDING INDUSTRY ASSOCIATION

Flathead Home Builders Assoc.
752-2522

Missoula Chapter of NAHB
273-0314

Helena Chapter of NAHB
449-7275

EXHIBIT 1
DATE 2-17-93
HB 622

Nancy Lien Griffin, Executive Director
Suite 4D Power Block Building • Helena, Montana 59601 • (406) 442-4479

HB 622
Temporary Partial Disability, Apportionment of Preexisting Conditions

Recommend:
Do Pass

Mr. Chairman, Ladies & Gentlemen of the Committee:

I am Harlee Thompson, manager of Intermountain Truss in Helena, and a delegate from the Montana Building Industry Association to the Coalition for Work Comp System Improvement (CWCSI).

This bill represents several important changes which have been considered by the Coalition for Work Comp System Improvement (CWCSI). After extensive review of all of the diverse Work Comp proposals before this Legislature, the Coalition has offered this legislation as a vehicle for introduction of issues we have considered in our interim meetings which were not considered by other groups concerned about Work Comp reform.

The most important aspect of HB 622 is the identification of preexisting injuries. These injuries have proved to be a major drain on the Work Comp system. An injury not solely related to the particular claim is often solely a Work Comp liability. This bill, HB 622, authorizes the apportionment of preexisting conditions, which does not serve to limit benefits, but assigns liability to the appropriate rate payers.

Another critical component of this legislation is the creation of the definition for temporary partial disability. The coalition has discussed at length the need for this addition to Work Comp injury definitions. The categorization of temporary partial disability encourages employers, employees and insurers to find alternative work placements within allowable medical limitations. This alternative work placement reduces insurer benefits, but allows the employee earned income, ~~which in total is in excess of what benefits would be~~. This encourages early return to work, yet limits system liabilities. Authorization of this alternative work placement is dependent upon acceptance by the employee and releases doctors from liability if acceptable medical practices have been followed.

Some other important issues corrected by this legislation are as follows:
1. HB 622 gives the insurer direct access to medical records.
2. Allows suspension of benefits for unreasonable failure to keep medical appointments.
3. Allows workers and insurers to negotiate for termination of benefits.
4. Ask that insurers appraise workers and employers of medical progress & potential benefits.
5. Assesses fines for uninsured employers in the amount of 10 times what their unpaid premium would have been.

These are critical changes to getting more employers on the system, encouraging early return to work and limiting Work Comp system expenses, yet retaining the level of benefits and injury compensation for injured workers.

We urge a do pass for HB 622

EXHIBIT 2
DATE 2-17-93
HB 622

REQUEST FOR AMENDMENT--House Bill 622

PAGE 11. Line 18,

Following: "designated"
INSERT: "rehabilitation"

Line should read,"...insurer's designated rehabilitation agent direct access to medical service...."

RATIONALE:

This language was formulated in direct response to the difficulties encountered by rehabilitation nurses who are asked by insurers to assist them by providing medical case management and medical services coordination for selected worrkers comp cases. At the present time injured workers must comply with vocational rehabilitation providers, but there is no provision for registered nurses who are assisting with case management for the insurer. Those firms providing this service have been hindered by attornies who refuse to allow the case manager access to their client to assess their medical status/condition. This language assists/supports those insurers using nurse case managers for managed care on difficult cases.

NOTE:
There is similar language in Senate Bill 347; however, it pertains to managed care and compliance to medical treatment only. By also keeping this language in the statutes, AND by including the additional descripto you will ensure injured worker cooperation with medical case managers regardless of whether they are a part of a managed care program under the new managed care legislation/definitions, or they are a part of an existing rehabilitation/managed care effort on a workers comp. case.

Norm Grosfield

EXHIBIT 3
DATE 2-17-93
HB 622

Amendments to House Bill No. 622

1. Page 10, line 13.
   Strike: lines 13 through 25

2. Page 11, line 1,
   Strike: lines 1 through 3

3. Page 23, line 16, and pages 24 and 25.
   Strike: New Section 13 in its entirety

EXHIBIT 4
DATE 2-17-93
HB 622

Amendments to House Bill No. 622

1. Page 20, line 9.
Strike: lines 9 through 15

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Select Workers Comp COMMITTEE BILL NO. 622

DATE 2-17 SPONSOR(S) REP. D. EWER

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Roxanne Vernon-Hinz	Self		
Rick Hill	Gov. Office	—	—
Bill Crivello	Labor Assn of MT	x	
Jim Murphy	State Fund		x x
Jon Ellis	CAFCSE	x	
Charles R. Brooks	MT Retail Assoc	x	
HARLee Thompson	MBIA & CWCSI	x	
Jim Twinley	MT Chamber	w/ AMD	
JAMES D. FURMAN	Coalition for Work Comp	x	
Bill Conner	CWCSI	x	
Kent Kleinkopf	self	x	
Jan Van Riper	self		x
Jacqueline Lenmark	Am. Ins. Assoc.		x
Kelly Johnson	NFIB	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Select Workers Comp COMMITTEE BILL NO. 622

DATE 2-17-93 SPONSOR(S) REP. D. ENGR

PLEASE PRINT **PLEASE PRINT** **PLEASE PRINT**

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
George Wood	MT Self Insurers Assoc	With Amendments	
[illegible]	MMIA-MSGIA-MACO	✓	
Russell B Hill	MTLA		—
Don Judge	MT STATE AFL-CIO	Amend	Amend
Mark Egan	MT Conf. of Elect. Wkrs.	Amend	Amend

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By **CHAIRMAN CHASE HIBBARD**, on March 12, 1993, at 3:00 p.m.

ROLL CALL

Members Present:
Rep. Chase Hibbard, Chairman (R)
Rep. Jerry Driscoll, Vice Chairman (D)
Rep. Steve Benedict (R)
Rep. Ernest Bergsagel (R)
Rep. Vicki Cocchiarella (D)
Rep. David Ewer (D)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Council
Evy Hendrickson, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: HB 672
Executive Action: HB 453, HB 455, HB 504, HB 622, HB 672

HEARING ON HB 672

Opening Statement by Sponsor:

REP. DAVID EWER, House District 45, Helena, presented HB 672. He said the purpose of this bill is to meet the anticipated cash needs of the old fund for the next biennium using an increased rate of payroll tax which would be borne by employers. **REP. EWER** said this bill makes changes to existing law, and he then reviewed the bill section by section. **REP. EWER** said this bill would enable the Board of Investments to size a bond issue based on growth of payroll tax which was not an option in the past. He said under existing statute the sizing of the bond issue is strictly limited to what has happened in the past.

REP. EWER said the payroll base has been rising close to 5% per year over the last ten years. Changes in the wording in this bill, should the payroll base fail, would enable the tax rate to go up, if required. He said the payroll base is unlike an income

Motion: REP. EWER MOVED HB 672 DO PASS AS AMENDED. Voice vote was taken. Motion carried unanimously.

EXECUTIVE ACTION ON HB 622

Motion: REP. EWER MOVED HB 622.

Discussion: REP. EWER said he had asked **Susan Fox** to categorize the amendments by subject. He said there were nine sets of amendments, and the committee would address the amendments brought by the coalition.

Jim Palmer reviewed the Coalition amendment. **EXHIBIT 2**

REP. DRISCOLL asked why the injured person is limited to 26 weeks. **Mr. Palmer** said the intent of the section is to provide an incentive to both the employer and employee to move towards returning to the work place. He said if the individual is unable to continue to work in that job position over a period of approximately six weeks, it's going to be relatively obvious that the worker is not going to be able return indefinitely. He said the individual should then go back to temporary total disability if he has not reached maximum healing or, if maximum healing has been reached, then he would move on to rehabilitation. After six months, if the individual is not able to return to work at the job at which he was injured, then in all probability he will not be able to.

Mr. Palmer said this part of the amendment is nothing more than a temporary incentive to both the employer and the employee. He said that currently there is no provision to allow for this benefit. The individual is temporarily totally disabled or, if he does return to work under the current definition of temporary total, he returns to the same or equal pay in a modified job position. He said there are situations where the employer cannot afford to pay the individual his full wages for modified work and this will allow the insurance carrier to make up the difference between what the employer can pay and what the individual's temporary total rate would be.

REP. DRISCOLL said this is very important wording; "return to job at time of injury" in the amendment because they could discontinue his workers' comp and tell him to get a job at the 7-11 store and then he would not be entitled to rehabilitation.

REP. DRISCOLL said amendment 14 talks about time of injury; that's whether or not they are going to get a rehabilitation person to write a plan and that provider has to determine whether or not the injured person can return to any type of work so the words "return to the job at the time of injury" have to be put in Amendment 14, page 19, line 20. **Susan Fox** said she would change the amendment.

Motion: **REP. DRISCOLL** moved to amend the amendments.

DISCUSSION: **REP. DRISCOLL** said instead of inserting "work" and striking "the job," he present bill says "return to the job" and we have to add the words "held at the time of injury" to the amendments.

Vote: **REP. EWER** called for the question. Voice vote. Motion carried 5-0 to amend the amendments with **REP. BERGSAGEL** not present.

DISCUSSION: **CHAIRMAN HIBBARD** suggested that the committee figure out the amendments by next Tuesday so it does not duplicate other action.

Motion: **REP. DRISCOLL** moved that amendment number 23 be removed from the first amendment.

Discussion: **Jim Palmer** said the purpose of the temporary, partial disability is to provide an incentive to both the employer and employee to return to work. He said the intent is not to exceed the temporary and total disability.

REP. DRISCOLL said the coalition's minutes clearly show that the intent of the coalition is if the worker returned, he or she would get the same money received when they were working between the new wages and comp. He said if the committee accepts this amendment, one-half the weekly wage -- which is $175.00 -- would be paid if the person returns to employment at 40 hours per hours a week, minimum wage, at $160.00 minus taxes, $175.00 from this amendment; they are not half-way whole much less made whole. **REP. DRISCOLL** said his point is, why would they take the job? It would be only because it was law and they would be forced to. He said people receiving a higher wage at the time of injury are already subject to $349.00 a week temporary total and then he would be forced to go back to a temporary, partial disability taking a job at minimum wage and give him $175.00 a week temporary, partial disability benefits. **REP. DRISCOLL** said that is not the intent of the minutes of the coalition meeting. He said welders, electricians and higher wage earning workers would really suffer under this amendment.

Jim Palmer said there is some confusion regarding the intent of the temporary, partial and he thinks until it is resolved it would be better to strike Section 14 "temporary, partial" than it would be to go ahead with the present confusion.

REP. EWER asked if the injured worker can work while on temporary, total. **REP. DRISCOLL** said they cannot because it would be fraud and they could be put in jail.

Jim Palmer said if we expand temporary, partial to exceed the current standard of two-thirds the state's average weekly wage, there is a fear that there may be a precedent set as to why we

should not exceed two-thirds of the state's weekly average wage on all the other types of benefits.

Motion: **REP. DRISCOLL** moved to adopt the amendments with the exception of #23, the average weekly wage.

Discussion: **Susan Fox** clarified amendment #5, page 9, line 24. The intent is to leave the language so that language in HB 361 would take precedence; if that is what the committee wants, we cannot strike subsection 4 in its entirety because that would remove it from law. She said what we would need to do is return it to current law status as it is now and then the amendment in HB 361 would take over and House Labor Committee would not have to deal with it.

Ms. Fox said it should say "return Subsection 4 to current language." The committee agreed.

Harlee Thompson clarified this by saying the insurer would be liable for the maximum of the $349,00, which is the two-thirds of the average weekly wage currently in effect and whatever the injured worker would earn working as long as that didn't exceed his forty hours pay. **Mr. Thompson** asked **REP. DRISCOLL** if that is what his amendment says. **REP. DRISCOLL** said it would have to say "not to exceed the state's average weekly wage," not "one-half the weekly wage." He said if he puts in a new #23, not to exceed the state's average weekly wage at the time of injury, then it would be doing what he said.

REP. DRISCOLL withdrew his motion.

Motion/Vote: **REP. DRISCOLL** moved to adopt Amendment #23 striking "one-half of" following "disabled" on line 24; insert "not to exceed the state's average weekly wage at the time of injury." Voice vote was taken. Motion carried unanimously.

Motion/Vote: **REP. DRISCOLL** moved adoption of the remaining amendments. Voice vote was taken. Motion carried unanimously.

Discussion: **Mr. Palmer** reviewed the second Coalition amendment section by section. **EXHIBIT 3**

CHAIRMAN HIBBARD asked **Ms. Butler** to explain how the amendment would work in current law and what the implications of this change would be. **Ms. Butler** said with an aggravation of a pre-existing condition, the insurer accepts that pre-existing condition along with the injury and pays benefits based on the combination of the result. After a worker meets maximum healing and he is essentially back to where he was when injured, there is leeway where the insurer is no longer liable. She said generally they take the worker as they find him until he reaches maximum healing and at that point his benefits would be reduced if he had a pre-existing condition. **Ms. Butler** said if there happened to be a prior work comp claim and it wasn't settled, but the

eligibility requirements were there and the original was fifty-fifty, the first insurer would be responsible for 50% and the second insurer responsible for the other 50%.

CHAIRMAN HIBBARD asked whether, under current law, a worker would get more benefits for a shorter period of time than this contemplates? **Ms. Butler** said under current law, a worker gets more benefits for a longer period of time. She said not only do they get benefits before maximum healing but they receive benefits after maximum healing. It's unusual to get a worker totally back to where they were before the injury and generally they stay on the entire liability so this would limit benefits compared to now.

CHAIRMAN HIBBARD said this is a fairly radical departure from what is being done now and he asked how this would be administered. **Ms. Butler** said if there was a prior insurer on the claim, it would be more difficult to administer because there would be two insurance companies. She said if there were two insurance companies involved, there would be a potential for litigation and they would be splitting the liability and have to agree on what benefits were payable. **Ms. Butler** said there would be a lot of administration difficulties.

CHAIRMAN HIBBARD said he was in a quandary as this is a fairly major departure and he wasn't really sure how he feels about it.

Ms. Fox said if the committee rejects these amendments, it may want to do a substitute amendment to strike that section in its entirety, which would return it to the status quo.

Motion/Vote: **REP. DRISCOLL** moved to amend bill by striking Section 3 in its entirety. Voice vote taken. Motion carried 4-2.

Motion: **REP. BENEDICT** moved adoption of the first Ewer amendment. **EXHIBIT 4**

Discussion: **CHAIRMAN HIBBARD** said this amendment is group purchase of workers' compensation insurance.

Mike Micone explained he had received information recently on the possibility of purchasing group insurance through the State Fund. He said this would go hand in hand with **Ms. Lenmark's** proposed amendments. It will allow groups like small trucking firms to form a group and buy a group policy. He said one other side benefit would be the possibility with the premium being kicked up because of the numbers in the group which could entice private carriers to come into the state. He said this was written almost verbatim from the Texas law. He asked that, if the committee does adopt this amendment, it delete subsection (7).

Ms. Fox clarified that section 18 (4) requires a department to adopt rules on forms criteria procedures and this requires a

statement of intent. She asked for the committee's direction to ask **Mr. Micone** to supply information on a statement of intent if this should pass.

Jacqueline Lenmark, from the **American Insurance Association (AIA)**, said **Mr. Micone** was accurate in his statement and it gives small employers the option to form a group so they might obtain compensation coverage at a better rate or it would give them some other options for carriers.

REP. COCCHIARELLA asked **Jim Murphy** to respond on how this would work in Montana. **Mr. Murphy** said no one knows how this would work. It may be very good in concept, but he said insurance companies can still turn down business and the State Fund cannot.

REP. DRISCOLL said this would have to be bought from an insurer authorized to write workers' compensation in the state and suggested that, since this concept is new, the committee could insert language that the State Fund does not have to comply with this section.

REP. BENEDICT asked if this would also give the opportunity for people who are now covered under the State Fund to get private insurance. He said they cannot get it now because maybe they are not large enough; if they get into a group of 10 or 15, they could get out of the State Fund and lose those premiums. **Mr. Murphy** said if this bill passes it would allow them to do that.

CHAIRMAN HIBBARD said they would need to find an insurance company to write their policies for them and this is an option of coverage from someone else and not opting out of coverage. **Mr. Murphy** said that is correct and assuming that the State Fund is given the option of writing or not writing it, then they would have to find someone to write it.

Mr. Micone said this amendment was not to encourage private insurers to come into the state. He said it was primarily aimed at the State Fund because there are a number of small employers who could group together and possibly get volume discounts. **Mr. Micone** said the employers being discussed are presently covered by the State Fund.

REP. DRISCOLL asked if there was a group of 10 truckers, and one individual in the group is causing all the wrecks, can he be eliminated from the group? **Mr. Micone** said he thought because they would have to form a governing body, they would be rating those individuals either in the form of higher premiums and they would have the authority to kick someone out of the group. **REP. DRISCOLL** asked if anyone can get out of the group if they want and **Mr. Micone** responded yes. He said this is very new to him but as he understands, the group would receive a base rate and companies within that group would receive volume mod factors.

Ms. Lenmark said it probably would be more appropriate to have

the plan filed with the insurance commissioner the same way it is done with the premium credit plan for the construction industry, and allow the State Fund, if they choose to participate, to develop its own plan because the private companies need to be regulated by the insurance commissioner.

REP. BENEDICT withdrew his motion.

CHAIRMAN HIBBARD said this amendment will stay on the table.

Discussion: **CHAIRMAN HIBBARD** said this amendment is requested by **Ms. Lenmark** to allow certain large deductibles. **EXHIBIT 5**

Ms. Lenmark said this amendment would provide an option for Plan 2 and Plan 3 insurers, allowing the State Fund or the private carriers to develop a plan to offer large deductibles to their policyholders. She said this is different from the deductible sections currently in law. **Ms. Lenmark** said this would allow the employer and insured to negotiate with their insurance company a deductible in some given amount. The insurance company would then be entitled to reduce the premium by some percentage amount based on the deductible negotiated. The insurance company is then on the hook for all the benefits. At the end of the year, the insurance company would collect the amount of deductible back from the employer. This is a contract between the insurer and policyholder. It does not have any impact at all on benefits or claims processing. The benefit of this particular large deductible plan is it offers some middle ground between self insurance and conventional insurance. **EXHIBIT 6**

Ms. Lenmark said this would allow an employer who is not quite large enough to self insure, but who would like to assume some of that liability, to make the arrangements to do so.

CHAIRMAN HIBBARD commented that this is one of the better options the committee has heard.

Motion/Vote: **REP. EWER** moved adoption of the amendment. **REP. BENEDICT** called for the question. Voice vote. Motion carried unanimously.

Motion: **REP. EWER** moved adoption of the second Lenmark amendment. **EXHIBIT 7**

Discussion: **Ms. Lenmark** representing AIA said the amendments were presented to the committee with **SEN. HARP's** fraud bill and it was decided that they should be held for consideration with this bill. She said this concept was developed by the Governor's task force, approved unanimously by the subcommittee chaired by **CHAIRMAN HIBBARD**, and inadvertently omitted from **SEN. HARP'S** bill.

Ms. Lenmark said this amendment would provide for the suspension of licensing discipline against professionals who abuse the

system. She referred to page 7, section 24 listing certain prohibitive activities to deter professionals and others from abusing the system. These are provider directed requirements.

Vote: **REP. BENEDICT** called the question. Voice vote. Motion carried unanimously.

Motion: **REP. EWER** moved adoption of the second Ewer amendment. **EXHIBIT 8**

Discussion: **REP. EWER** said the purpose of this amendment is three-fold: to increase the board from five to seven members; potential members would be selected by a panel consisting of the insurance commissioner and the leadership of the House and Senate who would recommend nominees to the Governor; the Governor would choose from that panel. Under this amendment board members would be paid $12,000 a year because this is an incredibly important board. The next major point of this amendment is the board has to adopt a business plan no later then June 30.

Ms. Fox said this would be inserted in the section that describes the duties of the board.

CHAIRMAN HIBBARD said he was somewhat nervous about the political appointments and the large salary. **REP. COCCHIARELLA** said this would give the Governor five appointments and the board should be totally balanced.

Vote: **REP. BENEDICT** called for the question. Voice vote. Motion carried unanimously.

Motion: **REP. EWER** moved adoption of Ewer amendment #3. **EXHIBIT 9**

Discussion: **REP. EWER** said the MEA brought the amendment to him.

REP. DRISCOLL said if a person gets injured on the job, has sick leave on the books and it is negotiated, they could receive temporary total and sick leave at the same time or use their vacation time.

Vote: Voice vote was taken. Motion carried unanimously.

Motion: **REP. COCCHIARELLA** moved to strike all of the language in section 10 and return it to the status quo. **Ms. Fox** said because the committee struck section 3, that returns the injury portion back to how it exists today and by striking section 10, we would return the aggravation section for occupational disease to the status quo.

REP. DRISCOLL said currently it says the compensation payable under this chapter must be reduced and limited to such portion and medical and now they will prorate medical if the bill is left as is so "and medical" has to be removed.

Vote: **REP. BENEDICT** called for the question. Voice vote. Motion carried unanimously.

Motion/Vote: **REP. COCCHIARELLA** moved to strike section 10, page 17, line 17. **REP. BENEDICT** called for the question. Voice vote. Motion carried unanimously.

Motion/Vote: **REP. BENEDICT** moved to strike section 4, page 11 and 12, to line 3. Voice vote. Motion carried unanimously.

Motion: **REP. COCCHIARELLA** moved to strike page 11, line 16-19.

Discussion: **REP. COCCHIARELLA** referred to page 11, line 16 and said this language, which has already amended compensation entitlement benefits for an injury or occupational disease, allows the insurer's designated agent direct access. She said this language violates every protection of privacy between a claimant and their lawyer and doctor, and that means any medical record or anything the insurer wants they can get. This would do away with a person's protection of privacy under the Montana Constitution.

Mr. Allen said other than hearing some of the discussion that went on in the coalition, this was put in the original bill and adopted after four months of discussion in various committees. **Mr. Allen** said when information is not available, it results in additional cost and the inability to process the claims in such a way that they can actually try to get at what really happened. He said if they can't get the information, they cannot make good decisions and he asked the committee not to accept that amendment.

John Shontz, representing **Vocational Rehabilitation Association (VRA)**, said there is language similar to this in SB 347. He said under current practice, VRA provides managed care using nurses and under SB 347 the nurses cannot access this information but every other medical provider can. He said VRA has asked that this language be amended to read "insurers' designated rehabilitation agent." This would provide nurses in the rehab programs with access to medical records. He suggested that the committee, rather than striking the language, change the language by adding the word "rehabilitation." **Mr. Shontz** said the sentence would read "insurers' designated rehabilitation agent."

REP. EWER asked **Ms. Butler** if she has access to the medical records of the treating physician under the current law. **Ms. Butler** said they can write the doctor and ask them to answer questions but the doctor is not bound to. **Ms. Butler** referred to the wording on page 11, line 16.

REP. EWER asked **Ms. Lenmark** how insurance companies protect the claimant's privacy but also get the information needed. **Ms. Lenmark** said the insurance company can request the information and the claimant can provide it. **Ms. Lenmark** said the intent was

to speed up the process to get benefits to the claimant, not to invade their rights.

Vote: **REP. BENEDICT** called for the question. Voice vote was taken. Motion carried unanimously.

Motion: **REP. BENEDICT** moved to strike subsection (8) & (9).

Discussion: **Ms. Fox** referred to subsection (8) and (9) on page 20 regarding rehabilitation benefits left out of the coalition amendments. **Ms. Butler** said it was a duplication and no longer needed.

CHAIRMAN HIBBARD said subsection (9) is in HB 361 and (8) is moved to page 19, line 4.

Vote: **REP. COCCHIARELLA** called for the question. Voice vote was taken. Motion carried unanimously.

Motion/Vote: **REP. EWER MOVED HB 622 DO PASS AS AMENDED.** Voice vote was taken. Motion carried unanimously.

EXECUTIVE ACTION ON HB 453

Motion/Vote: **REP. BENEDICT** moved to reconsider the committee's action of February 15 and moved adoption of the amendments. **EXHIBIT 10** Voice vote taken. Motion carried unanimously.

Motion/Vote: **REP. BENEDICT MOVED HB 453 DO PASS AS AMENDED.** Voice vote taken. Motion carried unanimously.

EXECUTIVE ACTION ON HB 455

Motion/Vote: **REP. BENEDICT MOVED HB 455 DO PASS AS AMENDED.** Voice vote was taken. Motion carried unanimously.

HB 455 goes directly to the floor.
HB 622 and HB 453 go with the package to the House Labor Committee.

EXECUTIVE ACTION ON HB 504

Motion: **REP. BENEDICT MOVED TO RECONSIDER ACTION ON HB 504 AND MOVED THE AMENDMENT. EXHIBIT 11**

Discussion: **Ms. Fox** said **Scott Seacat** brought up a coordination instruction problem on HB 504 that the committee adopted. She said the money is transferred for one fiscal year and the duties aren't transferred until the next fiscal year. She asked if someone could move to reconsider the action taken and remove the amendment so it can go back to the floor.

HOUSE OF REPRESENTATIVES
53RD LEGISLATURE - 1993
SELECT COMMITTEE ON WORKERS COMPENSATION

ROLL CALL DATE 3-12-93

NAME	PRESENT	ABSENT	EXCUSED
CHASE HIBBARD, CHAIRMAN	✓		
JERRY DRISCOLL, VICE CHAIRMAN	✓		
STEVE BENEDICT	✓		
ERNEST BERGSAGEL	✓		4
VICKI COCCHIARELLA	✓		
DAVID EWER	✓		

HR:1993
wp.rollcall.man

EXHIBIT 2
DATE 3-12-93
HB 622

Amendments to House Bill No. 622
First Reading Copy

Requested by (Coalition)
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 11, 1993

1. Title, lines 12 through 14.
Following: "INFIRMITY;" on line 12
Strike: the remainder of line 12 through line 14 in their entirety

2. Title, lines 17 through 19.
Following: "BENEFITS;" on line 17
Strike: the remainder of line 17 through "HIRING;" on line 19

3. Title, line 23.
Following: "AND"
Strike: "REPEALING" through "MCA"
Insert: "PROVIDING AN EFFECTIVE DATE"

4. Page 7, lines 1 through 4.
Following: "39-71-119" on line 1
Strike: the remainder of line 1 through "healing" on line 4
Insert: "in which a worker, prior to maximum healing:
(a) is temporarily unable to return to the position held at the time of injury because of a medically determined physical restriction;
(b) returns to work in a modified or alternative employment; and
(c) suffers a partial wage loss"

5. Page 9, line 24 through page 10, line 7.
Strike: subsection (4) in its entirety
Renumber: subsequent subsections

6. Page 10, line 23.
Strike: "(6)"
Insert: "(5)"

7. Page 11, line 16.
Strike: "applying"
Insert: "who apply"
Following: "compensation"
Insert: "or who are entitled to benefits"

8. Page 11, lines 20 and 21.
Strike: lines 20 and 21 in their entirety

9. Page 13, lines 24 and 25.
Following: "insurer" on line 24
Strike: the remainder of line 24 through "days" on line 25

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10. Page 14, lines 2 and 3.
Following: "payments" on line 2
Strike: the remainder of line 2 through "days" on line 3

11. Page 17, lines 17 through 23.
Strike: subsection (8) in its entirety

12. Page 19, line 2.
Following: "paid"
Insert: "biweekly"

13. Page 19, line 4.
Following: "plan"
Insert: "and are not subject to the lump-sum payment provisions of 39-71-741"

14. Page 19, line 20.
Strike: "the job" return to job
Insert: "work"

15. Page 20, line 6.
Following: "of"
Strike: the remainder of line 6
Insert: "the services and benefits available"

16. Page 20, lines 7 and 8.
Following: "to" on line 7
Strike: the remainder of line 7 through "section"
Insert: "the vocational rehabilitation provisions of the Workers' Compensation Act"

17. Page 20, line 10.
Strike: "with"
Insert: "to"

18. Page 20, line 12.
Following: "settlement"
Insert: "or be paid in a lump sum"

19. Page 21, line 2.
Strike: "an attending"
Insert: "a treating"
Following: "physician"
Strike: the remainder of line 2

20. Page 22, line 13 through page 23, line 15.
Strike: sections 11 and 12 in their entirety
Renumber: subsequent sections

21. Page 25, lines 14 and 15.
Following: "worker"
Strike: "is medically"
Insert: "has a physical restriction as determined by objective medical findings, and is"
Strike: "the same," on line 14

Insert: "a"
Following: "modified" on line 15
Strike: ","

22. Page 25, line 21.
Strike: "hourly"
Insert: "average weekly"

23. Page 25, line 24.
Following: "disabled"
Insert: "not to exceed one-half of the state's average weekly wage at the time of injury"

24. Page 26, lines 1 through 8.
Following: "weeks" on line 1
Strike: the remainder of line 1 through line 8
Insert: ".

(4) A worker requalifies for temporary total disability benefits if the modified position is no longer available to the worker and the worker continues to be temporarily totally disabled as defined in 39-71-116."

25. Page 26, lines 14 through 19.
Strike: section 15 in its entirety
Renumber: subsequent sections

26. Page 27, lines 16 and 17.
Strike: section 17 in its entirety
Renumber: subsequent section

27. Page 27, lines 18 through 23.
Following: "instruction." on line 18
Strike: subsection (1) in its entirety through "14]" on line 23
Insert: "[Sections 11 and 12]"

28. Page 28, line 1.
Strike: "13 and 14"
Insert: "11 and 12"

29. Page 28, line 2.
Following: line 1
Insert: "NEW SECTION. **Section 15. {standard} Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. **Section 16. {standard} Effective date.** [This act] is effective July 1, 1993."

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DATE 3/12/93
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Amendments to House Bill No. 622
First Reading Copy

Requested by Coalition
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 9, 1993

1. Title, lines 15 and 16.
Strike: line 15 through "DISPUTES;" on line 16

2. Page 10, lines 13 through page 11, line 3.
Following: "(6)" on line 13
Strike: the remainder of subsections (6) and (7) in their entirety
Insert: "If an injury, as defined in 39-71-119, occurs that involves an aggravation of a preexisting condition, the permanent total, permanent partial, and medical benefits payable under this chapter after the worker reaches maximum healing must be apportioned between the liability attributable to the preexisting condition and the liability attributable to the aggravation injury. The insurer for the injury is responsible only for the portion attributable to the aggravation injury.

(7) If a workers' compensation insurer had a compensable claim for the preexisting condition, the insurer remains liable for the portion attributable to that insurer for permanent total, permanent partial, and medical benefits."

3. Page 21, line 25 through page 22, line 3.
Following: "be" on page 21, line 25
Strike: the remainder of page 21, line 25 through page 22, line 5
Insert: "apportioned between the liability attributable to the preexisting condition and the liability attributable to the occupational disease after the injured worker reaches maximum healing.

(2) If a workers' compensation insurer had a compensable claim for the preexisting condition, the insurer remains liable for the portion attributable to that insurer for benefits paid."
Renumber: subsequent subsection

4. Page 22, line 6.
Strike: "reduced a proportionate amount"
Insert: "apportioned"

5. Page 23, line 16 through page 25, line 11.
Strike: section 13 in its entirety
Renumber: subsequent sections

6. Page 27, lines 19 and 22.
Strike: "15"
Insert: "14"

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7. Page 27, line 23.
Strike: "[Sections 13 and 14] are"
Insert: "[Section 13] is"

8. Page 28, line 1.
Strike: "[sections 13 and 14]"
Insert: "[section 13"

EXHIBIT 4
DATE 3-12-93
HB 622

Amendments to House Bill No. 622
First Reading Copy

Requested by Rep. Ewer
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 11, 1993

1. Title, line 20.
Following: "SELF-INSURE;"
Insert: "ALLOWING GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE;"

2. Page 1, line 24.
Insert: "STATEMENT OF INTENT
(This amendment requires that a statement of intent be attached to the bill because it requires the department rules to implement [Section 18(4)]."

3. Page 27, line 16.
Following: line 15
Insert: "

NEW SECTION. **Section 17. Definitions.** As used in [section 18], the following definitions apply:

(1) "Business entity" means a business enterprise owned by a single person, corporation, organization, business trust, trust, partnership, joint venture, association, or other business entity.

(2) "Group" means two or more business entities that join together with the approval of the department to purchase individual workers' compensation insurance policies covering each business entity that is part of a group.

NEW SECTION. **Section 18. Group purchase of workers' compensation insurance.** (1) On receiving approval of the department, two or more business entities may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

(2) To be eligible to join a group, the department shall determine that a business entity is engaged in a business pursuit that is the same as or similar to the business pursuits of the other entities participating in the group.

(3) The department shall establish a certification program for groups organized under this section and shall issue to eligible business entities certificates of approval that authorize formation and maintenance of a group.

(4) The department by rule shall adopt forms, criteria, and procedures for the issuance of certificates of approval to groups under this section.

(5) A group certified under this section may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state. Under an individual

policy, the group is entitled to a premium or volume discount that would be applicable to a policy of the combined premium amount of the individual policies.

(6) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group.

(7) Rating manual rules and rates must be used in computing the rates for policies under this section, and the rating organization shall determine any experience rating factor that is applied to those group policies.

(8) A group shall adopt a plan of operation that must include the composition and selection of a governing board, the methods for administering the group, and guidelines for the workers' compensation insurance coverage obtained by the group, including the payment of premiums, the distribution of discounts, and the method for providing risk management. A group shall file a copy of its plan of operation with the department."

Renumber: subsequent sections

4. Page 28, line 2.
Following: line 1
Insert: "(3) [Sections 17 and 18] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 17 and 18]."

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Amendments to House Bill No. 622
First Reading Copy
(Large Deductibles)

EXHIBIT 5
DATE 3-12-93
HB 622

Requested by (Lenmark)
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 10, 1993

1. Title, line 20.
Following: "SELF-INSURE;"
Insert: "ALLOWING CERTAIN OPTIONAL DEDUCTIBLES TO POLICYHOLDERS;"

2. Page 27.
Following: line 15
Insert: "NEW SECTION. **Section 17. Workers' compensation and employers' liability insurance -- optional deductibles.** (1) An insurer issuing a workers' compensation or an employer's liability insurance policy may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).

(2) A rating organization may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).

(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:

(a) Claimants' rights are properly protected and claimants' benefits are paid without regard to the deductible.

(b) Premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.

(c) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.

(d) Recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.

(e) The policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(f) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the policyholder for the applicable deductible amount.

(g) Failure by the policyholder to reimburse deductible amounts to the insurer is treated under the policy as nonpayment of premium.

(h) Losses subject to the deductible must be reported and recorded as losses for purposes of ratemaking and application of the experience rating plan on the same basis as losses under policies providing first dollar coverage.

(4) The state compensation mutual insurance fund, plan No. 3, may adopt the plan filed by the rating organization or adopt an optional deductible plan that meets the requirements of this

section.

(5) For purposes of 39-71-201, liability for assessments must be ascertained based on premiums collected, in the case of policies written under plan No. 2, or on the assessment levied, in the case of policies written under plan No. 3, for which the policyholder would have been obligated without the deductible. For all other taxes and assessments based on premium, the amount of premium or assessment must be determined after application of the deductible."

Renumber: subsequent sections

3. Page 28.
Following: line 1
Insert: "(3) [Section 17] is intended to be codified as an integral part of Title 39, chapter 71, part 4, and the provisions of Title 39, chapter 71, part 4, apply to [section 17]."

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WORKERS COMPENSATION DEDUCTIBLE CONSIDERATIONS

EMPLOYER INCENTIVES

The cost differentials between insured and self insured programs are increasing, and they provide definite incentives for employers to self insure or find some other means to self fund a large amount of their Workers Compensation benefits. These cost differentials are principally driven by the following:

1) The statutory surplus required to guarantee benefits is becoming increasingly more expensive. A large Employer's internal rate of return is invariably such as to show at least a 5% advantage for self funding.

2) The Federal Tax Reform Act of 1986 requires that Property and Casualty loss reserves be discounted. The impact of this on Workers Compensation Insurers is a 4% increase in costs. There is no impact on a Self Insurer.

3) Insurer taxes and assessments have all increased significantly. Insurers now pay from 1% to 10% of premium in taxes, assessments and fees. Self Insurers pay 1% to 5% less of imputed premium - an invariably lesser base as well as a lesser rate.

4) Residual market costs for Workers Compensation Insurers have exploded to 16% of voluntary premium countrywide. Self Insurers do not participate and so, pay nothing.

With as much as a 25% cost disadvantage, conventional insurance plans - either guaranteed cost or loss sensitive - are no match for self insurance. However, large deductible plans can narrow the cost differential sufficiently to provide a reasonable alternative. This is accomplished by reducing the premium upon which these costs are based.

In addition, all the guarantees and services of conventional insurance programs are provided as a further incentive. And finally, by remaining in the insurance system, the necessary framework is maintained for the employer to exercise various other insurance options in the future.

UNDERWRITER INCENTIVES

Survival in any business is predicated on response to customer preference. Employer demand for traditional insurance guarantees and services packaged with the cost savings of self funding is the underwriter's principal incentive.

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Surplus is a scarce resource. If it can be used to underwrite more business and provide comparable security, an increase in productivity results. The same is true for loss reserves particularly now that they must be discounted. The result can be a more attractive return from a line of business which has grown increasingly less attractive.

CLAIM HANDLING

The hallmark of Workers Compensation Insurance is the insurer's direct and impartial relationship with and responsibility to the injured worker. Regardless of how the employer funds the benefits, this responsibility and relationship must be maintained for a deductible plan to be a bona fide alternative to conventional insurance. So the insurer must not only adjust all claims from first dollar, but be the sole guarantor of all claims as well.

REIMBURSEMENT PROVISION

Since the insurer is solely responsible for claim payments the standard Workers Compensation Policy must be used as the coverage vehicle. An endorsement provision for reimbursement of deductible losses by the employer must be established in such a manner as to provide no greater threat to benefit guarantees than non payment of premium would under conventional insurance.

SECURITY

The employer's reimbursement agreement serves the same purpose as respects losses within the deductible that surplus and loss reserves would serve otherwise. It must fully support the insurer's financial capacity to pay claims. Therefore, a cash deposit is required to fund current claim payments and an irrevocable letter of credit on a bank acceptable to the insurer is required to fund ultimate future claim payments.

APPLICATION

In order to respond to risk management principles, required reimbursements must be reasonably predictable, protect the employer against catastrophe and afford the opportunity to manage the risk. Including allocated loss adjustment expense in the definition of deductible loss provides for risk management involvement. Applying the deductible limit to all injuries arising from a single accident and each person for disease, protects against catastrophe, and is consistent with the standard employers liability approach.

EXPERIENCE RATING

EXHIBIT_____

DATE_____

Standard premium is the point of reference by which the cost of all Workers Compensation benefit funding arrangements can be compared. It represents the established price for a fully insured program on a guaranteed cost basis; and, given reasonable rate adequacy, provides a basis for underwriting a risk. Thus the integrity of experience rating should be maintained so as to provide the basis for future insurance options.

PRICING

The premium credit for a deductible should identify that portion of an individual employer's premium which is designed to fund losses within the deductible limit. Therefore it should be applied to the employer's otherwise applicable standard premium.

The remainder of the standard premium should be unaffected by the deductible credit since the guarantees and services funded by the remainder are unchanged. So premium discount should also be based on the otherwise applicable standard premium.

Deductible plans are designed to encourage more effective employer implementation of cost control measures. To the extent that these are implemented there should be a means for recognizing their anticipated result. Parameters should be established as well as the means for regulatory oversight.

DATA REPORTING

Current data calls provide sufficient information to establish proper deductible credit formulas. So long as unit statistical data is reported gross, ignoring deductible impact, existing rate making and individual risk experience rating mechanisims will be preserved. Allowing net losses and credited premiums to impact rate making and experience rating will undermine each, and undermine the basis for underwriting flexibility which employers would want preserved.

ELIGIBILITY

We must be careful not to encourage the purchase of deductible coverage by employers who are neither sufficiently risk management oriented nor financially responsible. Those who would gamble that no losses would occur rather than prudently fund and manage them, will cause great grief to themselves and the insurance industry.

To the extent that political expectations will permit, eligibility requirements should discourage all but the relatively few employers who can effectively use the plan as part of an overall program to manage workers compensation benefit costs.

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Excess Loss Premiums and Insurance charges based on industry claim data by state, provide the basis for a deductible credit formula sufficient to discourage those who should be discouraged. We should resist pressure to reduce these risk charges in an attempt to make the plan attractive to more employers.

DISCRIMINATION

Deductible Plans are designed to provide larger employers with the means for funding and administering their Workers Compensation benefits within the insurance system. We are convinced that involvement of these large employers in the system is critical to its continued viability. They not only provide needed funding but leadership and inovation as well.

The incentive for them to remain is partly based on reduced costs for programs funded by assessments against premium. Otherwise the incentive is for them to leave or stay out and provide no funding for the residual market deficit, no contribution to insurance industry surplus, no insurance guaranty fund support, and no taxes and premium based assessments. Those relatively few employers who can self fund will do it. The only question is whether they will do it within the insurance system and provide some support for it or self insure and provide none.

This could be perceived as discriminatory against smaller employers and their insurers who would have to share a larger proportion of the burden. However a broader question is whether its to the industry's advantage to have some participation from the larger employers or none. If it's none then the proportion for the smaller accounts is total and the actual cost is greater. If it's some then their actual cost is less and their proportion is less than total.

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Backgrounder on Workers' Compensation Large Deductible Plans

October 25, 1992

What are large deductibles?

A new insurance product for workers' compensation coverage is now available from many insurers - large deductible plans. Workers' compensation coverage is mandatory for most employers. Traditionally, workers' compensation insurance was available only with first dollar coverage. Employers willing to take the entire risk could self-insure -- if they qualified. However, there was no insurance product for employers who wanted to take some of the risk. Large deductible plans fill this gap.

Why large deductibles should be available

There a number of reasons to allow authority for large deductibles.

✓ *Responsive to demand* - employers want the flexibility to choose taking part of the risk without having to take the entire risk, while continuing to receive professional claims, loss control, and other services from the insurer. Unlike self-insurance, a large deductible protects the employer against catastrophic loss.

✓ *Security for injured workers* - large deductible plans provide for direct payment of benefits by the insurer, including the deductible amount, subject to reimbursement from the employer. These plans provide workers and state officials the confidence of knowing that benefits will be paid as required. The insurer, not the injured worker or the state, takes the risk of collecting amounts owed by the employer.

✓ *Safety and return to work incentives* - by taking part of the risk, the employer has additional financial incentive to prevent injuries. At the same time, the deductible gives employers strong financial incentive to better control claims costs through effective return to work programs.

✓ *Promote insurance availability* - large deductible plans enable insurers to compete against self-insurance. Insurance is subject to taxes and assessments that generally do not apply to self-insurance. Most states levy a premium tax on all insurance policies. In addition, in many states

insurers are assessed to pay for any deficits in the workers' compensation assigned risk pool. The assessment, called a "residual market load" or RML, is levied on each insurer in proportion to its voluntary workers' compensation business - in effect, a subsidy from the voluntary market to the assigned risk pool. Premium taxes and the RML can create a significant competitive disadvantage for insurance, ~~because~~ because self-insurers are exempt. An insurance policy written with a large deductible has a smaller premium and thereby a reduced tax burden and RML - which may make it financially attractive to write compared to first dollar coverage for the same employer.

How do large deductibles compare to retrospective rating?

Most states already permit another form of loss-sensitive workers' compensation insurance coverage - retrospective rating. The question arises how large deductibles differ from "retro" plans. Retrospective rating plans provide a range - a minimum and maximum premium - with the over-all cost to the employer determined within that range based on the employer's claims experience. A large deductible plan is like a retro in the sense that the cost is sensitive to the employer's experience. However, it is more flexible, allowing an employer to attain greater savings by bearing more of the risk than would be allowed under a retro plan, while providing fully insured protection for losses over the deductible amount. Unlike a retro, the price is determined by the cost of the insured amount, plus actual claims costs (including an agreed allowance for the cost of claims adjustment and administrative fees for handling the account). Some large deductibles have no cap, but are based on the employer's losses. However, unlike self-insurance, these deductible plans require the insurer to pay the benefits and then seek reimbursement from the employer.

How are large deductibles regulated?

Insurers are permitted to use large deductible plans in most jurisdictions. Insurers wishing to use these plans file them with insurance regulators. In a few states, however, the insurance rating law or workers' compensation act has been interpreted to prohibit or severely restrict their use. For example, some states that expressly permit small deductibles at various dollar amounts - typically $500, $1000, $2500 - interpret the law to preclude large deductibles.

How do large deductibles affect state assessments and premium tax collections?

Normally state assessments and premium taxes are levied on insurance premiums on a *net* basis - after application of any price adjustments, including the workers' compensation experience

modifier, discounts, rate deviations, and other price adjustments. This practice applies equally to adjustments recognizing the price effect of the deductible.

In states where assessments are levied equally on insurers and self-insurers, there is no competitive advantage for self-insurance. For example, Idaho imposes a special assessment on insurers and self-insurers, with the proceeds dedicated to finance the Industrial Commission, which administers the state workers' compensation act. When assessments apply equally to insurers and self-insurers, AIA recommends that states use losses rather than premiums as the base, to help distribute costs fairly and accurately.

How do large deductibles affect the ratemaking process?

Insurers report losses on an aggregate basis, including amounts paid under deductibles. Reporting on a gross basis is needed to protect the integrity of the experience rating system and to maintain complete and accurate data to establish rates. Without this complete information, it would be difficult to know how to price the coverage with and without the deductible amount.

What are the arguments against large deductibles?

- Some insurers have objected to use of large deductibles by their competitors on grounds they reduce or redistribute the assessment base for the assigned risk pool as well as the premium tax base. However, they do not make a convincing case that large deductibles should be treated on a different basis from other competitive pricing adjustments and the uniform experience rating plan, which affect the base as well. Moreover, some employers would undoubtedly drop out of the assessment base entirely by self-insuring, if the pricing flexibility of large deductibles were not available. With respect to these employers, large deductibles actually preserve or expand the base.

- Some insurers also argue that large deductibles may give an advantage to their competitors who can afford to pay the deductible amount and collect back from the policyholder later. However, this is not a strong argument, because any insurer may extend credit to its policyholder over payment of premiums. An insurer wishing to use a large deductible plan may negotiate with its policyholder the schedule for collection of amounts paid under the deductible and any security requirements. In practice, insurers using large deductible plans establish dedicated policyholder-funded accounts and/or negotiate funding arrangements to use policyholder supplied resources to pay claims and expenses, thus there really is no significant extension of credit.

► Large deductibles will be used disproportionately by employers with good experience, constricting the first dollar coverage pool to smaller businesses and those with bad experience. Insurance may become prohibitively expensive for those remaining employers using first dollar coverage. However, this argument assumes that employers using deductibles would have remained in the insurance market. Moreover, to the extent employers with deductibles have better loss results, it is because they devote more attention to safety and make greater use of return to work programs to control their losses. Consequently, they *should* pay rates reflecting their true insurance exposure.

► Insurance regulators in a few states have raised solvency questions. If the deductible amount is very large and competitive pressures in the insurance market place are intense, they express concern that some insurers may take unacceptable risks. AIA recommends that insurance regulators address this concern in the filing process by refusal to approve plans for those few insurers whose financial condition gives rise to such concerns or by requiring that such insurers obtain adequate financial security for the deductible amount.

► Some insurance regulators have expressed concern that large deductibles will materially reduce the premium tax receipts used to finance insurance regulation, even though the burden of insurance regulation is no smaller. For example, regulators must make sure insurers are handling the deductible amounts properly and reporting them correctly for ratemaking. However, if the employer were to abandon insurance and self-insure, there would be an even greater reduction in tax receipts. Where the adequacy of adequate funding for insurance regulation is a concern, AIA supports reaching an accommodation if necessary to gain approval of otherwise acceptable deductible legislation.

► In a few states, workers' compensation agencies have raised objections that large deductibles are not permitted because they do not satisfy workers' compensation self-insurance laws. However, large deductibles are not self-insurance because they are used for employers who want to take part of the risk and because the insurer is responsible for payment of claims, including the deductible amount.

Security for deductible

A few regulators have proposed regulation of the security for the deductible amount furnished by the employer. Because this question is normally addressed in the negotiations between insurer and policyholder, AIA opposes regulation of the form or amount of security. States require security for self-insured

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employers, whose solvency is not regulated. Workers employed by insured employers with large deductible plans do not have the same risk as those employed by self-insurers, because benefits are guaranteed by the insurance carrier, whose solvency is regulated by state insurance departments. Unlike self-insurers, insurers have strong financial incentive to require adequate security from policyholders - an insurer will not make the deductible plan available unless it is confident of being reimbursed. Therefore, it is unnecessary to regulate the solvency of the individual employer using a deductible plan. Consequently, AIA opposes prescriptive criteria for the form or amount of the security.

Size of deductible amount and size of employer

In a few cases, regulators have recommended that large deductible plans be available only to employers whose premium is over a threshold. AIA does not advocate there be any minimum threshold but believes that if one is adopted it should not unduly restrict the flexibility to use these plans and that it should operate with a lower threshold for multistate employers.

AIA is opposed to arbitrary quotas restricting the number or premium volume of large deductible plans. Insurers should be permitted to offer these plans to all qualified policyholders interested in them.

AIA recommends that large deductibles be permitted in amounts negotiated between the employer and insurer. For employers interested in large deductibles, there is an arm's-length business relationship between the employer and the insurer which justifies greater flexibility.

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Are Large Deductible Plans a Way Out of the Workers' Compensation Crisis?

By Arthur Gilbert, CPCU
Aetna Senior Account Executive, National Commercial Accounts
from RIMI. Risk Management Section Quarterly

Over the past one and one-half to two years, several major writers of workers' compensation insurance have introduced large deductible workers' compensation plans and have actively solicited approval of such plans from insurance regulatory bodies of nearly every state. Where approval of these plans has been received, compensation large deductibles have been aggressively marketed to brokers and risk managers as a way of dealing with several of the shortcomings of the current workers' compensation market. The questions each risk manager must ask are: Will a large deductible plan be right for my company? Is it merely a gimmick, or is it something really worth my attention?

A New Application of an Old Concept

In order to answer these questions, we must first look at those characteristics of large deductibles which make them a workable option. After all, deductibles have been around for almost as long as insurance policies, and the idea of a large deductible as a loss-responsive rating plan is not new. Large deductible plans have been used successfully for decades as an alternative to retrospective rating for liability lines. Such plans often present unique advantages, both to the client and to the insurance carrier, which can make them highly attractive.

To define what we are discussing, in the casualty lines of insurance, any deductible of $25,000 or more is usually considered a "large" deductible. From a practical standpoint in today's market, however, a deductible of $100,000 per occurrence or more is common. Under a large deductible plan, the insurance carrier initially charges the client an up-front "handling fee" (deductible policy premium). This premium includes the carrier's expenses for overhead, profit, taxes, bureau fees, and the like. There is also a premium for coverages the carrier is providing in excess of the deductible amount to the policy limit of liability.

Beyond this initial handling fee, the client agrees to reimburse the carrier for losses up to the amount of the deductible selected. The carrier retains the responsibility for handling and payment of all claims from first dollar, with the client reimbursing the carrier for the amount of any loss within the limits of the deductible. In addition to the loss amount itself, the carrier may require the reimbursement of claim-handling expenses. Allocated expenses — those identified with the handling of a specific claim — are generally included within the loss reimbursement, while general claim-handling expenses are handled through a loading in addition to each reimbursement. Losses and claim-handling costs are usually reimbursed on an "as paid" basis. That is, the carrier makes a payment to a claimant and, within a specified time period, requests a reimbursement from the insured. Loss reserves are not subject to reimbursement.

Dual Advantages

The advantages to the insured lie in the cash flow provided. Most other loss-responsive rating plans, including retrospective rating, require reimbursement for paid losses and loss reserves. (Even if the client has a plan wherein only paid losses are reimbursed under a retrospective rating plan, the term of this deferment is usually only a few years.) Under a deductible rating plan, the client reimburses the insurer only for losses which are actually paid, and this reimbursement method remains as long as there are losses outstanding. For the average account, this will likely result in a more favorable cash flow pattern.

Conversely, the carrier enjoys advantages stemming from the fact that only the deductible policy premium (not loss reimbursements) is booked. This is important to carriers from the standpoint of policyholders, surplus requirements, and to carriers and insureds from the standpoint of premium taxes.

The Number One Issue

Workers' compensation has become the number one insurance issue for many businesses today. Ever-increasing loss costs, along with an overburdened assigned risk pool encumbered by individual state political and economic issues, have all contributed to the problem.

In the search for possible solutions, many risk managers are looking at self-insurance of workers' compensation in a way they would not have considered previously. However, self-insurance is not for all risks. Many states have strict financial requirements for self-insurance and the costs (often hidden) of loss control and claim handling must be provided and managed. There is also the potential of catastrophic workers' compensation loss for which insurance is essential. Often excess workers' compensation insurance is only available in a finite limit as opposed to a statutory limit provided by primary policies.

A Viable Alternative

Large deductible plans are a viable alternative to self-insurance, offering relief from many of the issues discussed, yet not creating a new set of dilemmas of their own. Under a large deductible workers' compensation plan, the insurance carrier retains all obligations under the law with regard to claim handling and payment, so the claim-handling mechanism remains fully in place. Unlike a retrospective rating plan, losses reimbursed under the large deductible plan are not considered premium and, thus, are not subject to premium tax. Eligibility for large deductible plans varies by state and by carrier, although, in general, an account producing $500,000 in annual premium may qualify. Finally, the plan utilizes a standard workers' compensation policy coverage form, so there is no difference in the statutory coverage provided under the deductible plan from that provided under other types of commercial rating plans. Thus, the need to consider excess insurance to cover statutory obligations in the event of a catastrophic situation is eliminated.

Limitations

Carriers that offer a large deductible plan stress its appeal, especially in comparison to other rating plans, as an alternative to self-insurance. Yet the large deductible is not without its limitations. First of all, the plan is not approved in all states. For an account with multi-state exposures and planning to insure all exposures commercially, some states may be written under a deductible plan, while others must remain on some other type of plan. The costs of administering such a split program may be higher than those of a single program. However this situation would be no different if there were a decision to partially self-insure. Second, there may be security requirements for a deductible plan, since most carriers will request security to cover losses. The amount and type of security will vary by carrier and type of plan filed. Finally, since deductibles are reimbursed on paid losses, a long and, perhaps, irregular payout pattern may be the rule, giving rise to the need for an in-house "funding" mechanism.

A Mixed Reception

To date the various state regulatory bodies have given large deductible programs a mixed reception. A study conducted by the Missouri Insurance Department in August 1990, and reported by the National Association of Insurance Commissioners (NAIC), noted that many state regulatory authorities saw large deductible plans as useful alternatives to self-insurance, but expressed specific concerns. Among those concerns were compliance with statutory requirements that the insurance carrier not be allowed to abdicate its responsibilities regarding payment of workers' compensation claims, and impact on statistical reporting.

The underlying premise of the large deductible plan is that a carrier retain the full responsibility for handling and payment of claims. In this respect, the large deductible is more of a reimbursement agreement than what is traditionally thought of as a "true" deductible. Likewise, under the large deductible format, the carrier is required to report fully all losses, including those within the deductible layer, and losses within the deductible layer are included in the calculation of an account's experience rating. These provisions differ sharply from those of small deductible plans, which are currently available in several states.

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Large Deductible Plans

(continued from page 33)

These latter plans represent true deductibles, since they generally apply to medical benefits only and are payable by the employer directly, and losses within these deductibles are not included in statistical reporting for experience rating.

While some states have rejected the use of deductible rating plans as being contrary to state laws, a number of states have either already enacted or are now considering modifications to state statutes to permit large deductible rating plans. The fact is that many states are recognizing the need for reform and are looking favorably on any plan which appears likely to generate improvement in the overall situation.

A Long-Term Solution

The large deductible plans that are being offered represent hope for risk managers trying to deal with some of the worst features surrounding the current workers' compensation crisis. However, it cannot be expected that any one rating plan can offer a total solution. The fact that carriers and state regulators have been receptive to the concept of deductibles in workers' compensation indicates an intense desire to change the overall picture for the better. The ultimate solution lies in reform of the workers' compensation system through cost control, rate adequacy, and depopulation of the residual markets. A concerted effort in support of reform on the part of all in the industry is the only permanent solution. □

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Author's note:

Since this article was originally written the interest in workers' compensation deductible plans has continued to increase. Aetna has filed two large deductible programs. One, in Farmington Casualty Company, is intended for National Commercial Accounts generating $500,000 or more in manual premium, and has been approved in about 30 states. The other, in Aetna Casualty and Surety, is for Standard Commercial Accounts generating $100,000 or more in manual premium. It is approved in about 22 states at the time of this writing.

The reference to a study commissioned by the Insurance Department of the State of Missouri is in no way intended to imply any particular predisposition either for or against the principle of deductible compensation insurance on the part of that regulatory body. Earlier this year, Missouri enacted legislation permitting carriers to offer deductibles to insureds.

The article states that small deductible plans differ from large deductible plans in that losses within small deductibles are not reported statistically or for experience rating. This point requires further clarification. The National Council of Compensation Insurance notes that of the nearly 20 states which have enacted small-deductible plans, about half require that losses be reported net of employer reimbursement, while the other half require reporting on a gross basis. NCCI staff members are currently studying the potential impact two different methods of loss reporting may have on the experience rating system, with the objective of minimizing any possible rating distortions. □

Agency Earns Special Thanks

The General Insurance Agency of Culpeper, Virginia, recently received the kind of thank-you note that puts insurers and agents in touch with just how important their work is.

The letter, from St. Stephen's Episcopal Church Rector Rev. H. Vance Mann III, a client of General Insurance, was an expression of gratitude for the support and assistance the agency had given the church when it was heavily damaged during a storm.

The letter, which General Insurance re-ran in its client publication, says:

"We have received hundreds of compliments from persons in the community about how handsome our reconstructed church looks after the extensive storm damage in July 1990. It's hard to believe it is the same church, and that the mess created by the storm could have been resurrected. Much of the credit for this is due to you and your agency and Bob Shiflet of Aetna.....

"...Your compassionate concern for our situation helped bolster our hope and determination to keep going. You constantly kept in touch with us to make sure we were getting the support and skilled help we needed. Consequently, repairs were made more quickly than I and others ever expected." □

CSRs Learn PRISMS

More often than not, customer service representatives are the public's first contact with a company. CSRs are also the major source of support for agents working to meet the needs of their clients.

With that in mind, Aetna's New York City office sponsored a seminar to expand and enhance the skills of the CSRs in its territory.

Called PRISMS for CSRs, the one-day course was held in the Aetna training room in the World Trade Center. More than 70 CSRs attended the seminar, which was offered for the first time last spring, according to Kendra J. Carson, homeowners sales representative in Aetna's New York City office.

The seminar covered communications, organizational skills, processing functions, errors and omissions and professional image.

"The program helped me realize that although I'm organized, I'm not as thorough as I could be," said Marygene Anderson, personal lines manager of Richards and Fenniman Agency. Nancy Anatra, a former Aetna employee who is now a CSR, said "The seminar really helped to change my perspective. I thought company first, agency, then client. Now I realize the client is always number one." □

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HB 622

Amendments to House Bill No. 622
First Reading Copy
FRAUD

EXHIBIT 7
DATE 3-12-93
HB 622

Requested by (Lenmark)
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 10, 1993

1. Title, line 20.
Following: "SELF-INSURE;"
Insert: "REQUIRING SUSPENSION, REVOCATION, OR DENIAL OF A PROFESSIONAL OR OCCUPATIONAL LICENSE FOR VIOLATION OF THE WORKERS' COMPENSATION LAW; REVISING THE DEFINITION OF UNPROFESSIONAL CONDUCT; PROHIBITING CERTAIN ACTIONS; PRECLUDING LIABILITY FOR REPORTING VIOLATIONS OF THE WORKERS' COMPENSATION LAW;"

2. Title, line 20.
Following: "SECTIONS"
Insert: "37-1-131, 37-3-322, 37-6-310, 37-10-311, 37-12-321, 37-14-321,"

3. Title, line 21.
Following: "39-71-307"
Insert: "39-71-316"

4. Page 27, line 16.
Following: line 15
Insert: "**Section 17.** Section 39-71-316, MCA, is amended to read:
"39-71-316. Filing true claim -- obtaining benefits through deception or other fraudulent means. (1) A person filing a claim under this chapter or chapter 72 of this title, by signing the claim, affirms the information filed is true and correct to the best of that person's knowledge.
(2) A person who obtains or assists in obtaining benefits to which the person is not entitled under this chapter or chapter 72 of this title may be guilty of theft under 45-6-301. A county attorney may initiate criminal proceedings against the person.
(3) A person licensed under the provisions of Title 37 is subject to suspension, revocation, or denial of a license if the person knowingly claims or assists in the claiming of benefits in violation of the provisions of chapter 72 or this chapter."

Section 18. Section 37-1-131, MCA, is amended to read:
"37-1-131. Duties of boards. Each board within the department shall:
(1) set and enforce standards and rules governing the licensing, certification, registration, and conduct of the members of the particular profession or occupation within its jurisdiction;
(2) sit in judgment in hearings for the suspension, revocation, or denial of a license of an actual or potential member of the particular profession or occupation within its jurisdiction. The hearings shall be conducted by legal counsel

when required under 37-1-121(1).

(3) suspend, revoke, or deny a license of a person who the board determines, after a hearing as provided in subsection (2), is guilty of knowingly defrauding, abusing, or aiding in the defrauding or abusing of the workers' compensation system in violation of the provisions of Title 39, chapter 71 or 72;

~~(3)~~(4) pay to the department its pro rata share of the assessed costs of the department under 37-1-101(6);

~~(4)~~(5) consult with the department before the board initiates a program expansion, under existing legislation, to determine if the board has adequate money and appropriation authority to fully pay all costs associated with the proposed program expansion. The board may not expand a program if the board does not have adequate money and appropriation authority available."

Section 19. Section 37-3-322, MCA, is amended to read:

"**37-3-322. Unprofessional conduct.** As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or in securing a license or in taking the examination provided for in this chapter;

(2) performing abortion contrary to law;

(3) obtaining a fee or other compensation, either directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition of a person can be cured;

(4) employing abusive billing practices;

(5) directly or indirectly giving or receiving a fee, commission, rebate, or other compensation for professional services not actually rendered. This prohibition does not preclude the legal functioning of lawful professional partnerships, corporations, or associations.

(6) willful disobedience of the rules of the board;

(7) conviction of an offense involving moral turpitude or conviction of a felony involving moral turpitude, and the judgment of the conviction, unless pending on appeal, is conclusive evidence of unprofessional conduct;

(8) commission of an act of sexual abuse, misconduct, or exploitation related to the licensee's practice of medicine;

(9) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors, otherwise than in the course of legitimate or reputable professional practice;

(10) conviction or violation of a federal or state law regulating the possession, distribution, or use of a narcotic or hallucinatory drug, as defined by the federal food and drug administration, and the judgment of conviction, unless pending on appeal, is conclusive evidence of unprofessional conduct;

(11) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other drug or substance to the extent that the use impairs the user physically or mentally;

(12) conduct unbecoming a person licensed to practice medicine or detrimental to the best interests of the public as defined by rule of the board;

(13) conduct likely to deceive, defraud, or harm the public;

(14) making a false or misleading statement regarding the licensee's skill or the effectiveness or value of the medicine, treatment, or remedy prescribed by the licensee or at the licensee's direction in the treatment of a disease or other condition of the body or mind;

(15) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(16) use of a false, fraudulent, or deceptive statement in any document connected with the practice of medicine;

(17) practicing medicine under a false or assumed name;

(18) testifying in court on a contingency basis;

(19) conspiring to misrepresent or willfully misrepresenting medical conditions improperly to increase or decrease a settlement, award, verdict, or judgment;

(20) aiding or abetting in the practice of medicine by a person not licensed to practice medicine or a person whose license to practice medicine is suspended;

(21) allowing another person or organization to use the licensee's license to practice medicine;

(22) malpractice or negligent practice;

(23) except as provided in this subsection, practicing medicine as the partner, agent, or employee of or in joint venture with a person who does not hold a license to practice medicine within this state; however, this does not prohibit:

(a) the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4;

(b) a single consultation with or a single treatment by a person or persons licensed to practice medicine and surgery in another state or territory of the United States or foreign country; or

(c) practicing medicine as the partner, agent, or employee of or in joint venture with a hospital, medical assistance facility, or other licensed health care provider. However:

(i) the partnership, agency, employment, or joint venture must be evidenced by a written agreement containing language to the effect that the relationship created by the agreement may not affect the exercise of the physician's independent judgment in the practice of medicine;

(ii) the physician's independent judgment in the practice of medicine must in fact be unaffected by the relationship; and

(iii) the physician may not be required to refer any patient to a particular provider or supplier or take any other action the physician determines not to be in the patient's best interest.

(24) willfully or negligently violating the confidentiality between physician and patient, except as required by law;

(25) failing to report to the board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

(26) failing to transfer pertinent and necessary medical records to another physician when requested to do so by the

subject patient or by the patient's legally designated representative;

(27) failing to furnish to the board or its investigators or representatives information legally requested by the board;

(28) failing to cooperate with a lawful investigation conducted by the board;

(29) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate parts 1 through 3 of this chapter or the rules authorized by them;

(30) having been subject to disciplinary action of another state or jurisdiction against a license or other authorization to practice medicine, based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section. A certified copy of the record of the action taken by the other state or jurisdiction is evidence of unprofessional conduct.

(31) any other act, whether specifically enumerated or not, which, in fact, constitutes unprofessional conduct."

Section 20. Section 37-6-310, MCA, is amended to read:

"**37-6-310. Unprofessional conduct.** As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or in securing a license or in taking the examination provided for in this chapter;

(2) obtaining a fee or other compensation, either directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition of a person can be cured;

(3) willful disobedience of the rules of the board;

(4) final conviction of an offense involving moral turpitude;

(5) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors, otherwise than in the course of legitimate or reputable professional practice;

(6) final conviction of a violation of a federal or state law regulating the possession, distribution, or use of a narcotic or hallucinatory drug, as defined by the federal food and drug administration;

(7) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other drug or substance to the extent that the use impairs the user physically or mentally;

(8) conduct unbecoming a person licensed to practice podiatry or detrimental to the best interest of the public;

(9) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(10) testifying in court on a contingency basis;

(11) conspiring to misrepresent or willfully misrepresenting medical conditions to increase or decrease a settlement, award, verdict, or judgment;

(12) aiding or abetting in the practice of medicine a person

not licensed to practice medicine or a person whose license to practice medicine is suspended;

(13) gross malpractice or negligent practice;

(14) practicing podiatry as the partner, agent, or employee of or in joint venture with a person who does not hold a license to practice podiatry within this state; however, this does not prohibit the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4, nor does this apply to a single consultation with or a single treatment by a person or persons licensed to practice podiatry in another state or territory of the United States or foreign country;

(15) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate parts 1 through 3 of this chapter or the rules authorized by parts 1 through 3; or

(16) any other act, whether specifically enumerated or not, which in fact constitutes unprofessional conduct."

Section 21. Section 37-10-311, MCA, is amended to read:

"**37-10-311. Revocation -- unprofessional conduct.** (1) The board may revoke a certificate of registration for:

(a) physical or mental incompetence;

(b) gross malpractice or repeated malpractice;

(c) a violation of any of the provisions of this chapter or rules or orders of the board; or

(d) unprofessional conduct.

(2) Unprofessional conduct includes:

(a) obtaining a fee by fraud or misrepresentation;

(b) employing, directly or indirectly, a suspended or unlicensed optometrist to perform work covered by this chapter;

(c) directly or indirectly accepting employment to practice optometry from a person not having a valid certificate of registration as an optometrist or accepting employment to practice optometry for or from a company or corporation;

(d) permitting another to use ~~his~~ the optometrists's certificate of registration;

(e) soliciting or sending a solicitor from house to house;

(f) treatment or advice in which untruthful or improbable statements are made;

(g) professing to cure nonocular disease;

(h) advertising in which ambiguous or misleading statements are made; ~~or~~

(i) the use in advertising of the expression "eye specialist" or "specialist on eyes" in connection with the name of an optometrist. This chapter does not prohibit legitimate or truthful advertising by a registered optometrist; or

(j) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or a claim for benefits under Title 39, chapter 71 or 72.

(3) Before a certificate is revoked, the holder shall be given a notice and an opportunity for a hearing.

(4) Any optometrist convicted a second time for violation

of the provisions of this chapter or whose certificate of registration or examination has been revoked a second time shall not be permitted to practice optometry in this state."

Section 22. Section 37-12-321, MCA, is amended to read:

"**37-12-321. Unprofessional conduct.** As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or securing a license or in taking the examination provided for in this chapter;

(2) obtaining any form of compensation, directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition can be cured;

(3) practicing chiropractic under a false or assumed name or impersonating another practitioner of like or different name;

(4) knowingly disobeying a rule of the board;

(5) conviction of a criminal offense involving moral turpitude. A certified copy of the judgment of conviction is conclusive evidence of the conviction. This subsection is subject to chapter 1, part 2, of this title.

(6) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other substance to the extent that such use impairs the user's physical or mental professional capability;

(7) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors;

(8) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(9) testifying in court on a contingency basis;

(10) conspiring to misrepresent or knowingly misrepresenting physical conditions in order to increase or decrease a settlement or award;

(11) aiding or abetting in the practice of chiropractic a person not licensed to practice chiropractic or a person whose license is suspended;

(12) practicing chiropractic as the partner, agent, or employee of or in joint venture with a person not licensed to practice chiropractic in this state. However, this does not prohibit incorporation as a professional service corporation under Title 35, chapter 4, or prevent a single consultation with or a single treatment by a person licensed to practice chiropractic in another state or territory of the United States or a foreign country.

(13) violating, attempting or conspiring to violate, or aiding or abetting in the violation of this chapter or the rules adopted under it; or

(14) conduct unbecoming a person licensed to practice chiropractic or detrimental to the best interests of the public."

Section 23. Section 37-14-321, MCA, is amended to read:

"**37-14-321. Revocation or suspension of license or permit.**

A license or permit may be suspended for a fixed period or may be revoked, or such technologist or technician may be censured, reprimanded, or otherwise disciplined as determined by the board if, after a hearing before the board, it is determined that the radiologic technologist or limited permit technician:

(1) is guilty of fraud or deceit in activities as a radiologic technologist or limited permit technician or has been guilty of any fraud or deceit in procuring the license or permit;

(2) has been convicted in a court of competent jurisdiction of a crime involving moral turpitude;

(3) is an habitual drunkard or is addicted to the use of narcotics or other drugs having a similar effect or is not mentally competent;

(4) is guilty of unethical or unprofessional conduct, as defined by rules promulgated by the board, or has been guilty of incompetence or negligence in his activities as a radiologic technologist or limited permit technician;

(5) has continued to perform as a radiologic technologist or limited permit technician without obtaining a license or permit or renewal as required by this chapter."

NEW SECTION. **Section 24. Prohibited actions -- penalty.** (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (3):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person licensed to practice law in Montana or a medical care provider who advertises services or facilities with the intention that a worker use those services or facilities with regard to an injury or illness that is compensable under chapter 72 or this chapter and who fails to announce in the advertisement that filing a fraudulent claim is theft, as provided in 39-71-316 subject to the penalty in subsection (3).

(3) A person who violates this section may be assessed a penalty of not less than $200 or more that $500 for each offense. The department shall asses and collect the penalty.

NEW SECTION. **Section 25. No liability for reporting violation.** A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith and without malice information that the person believes proves a violation of the provisions of chapter 72 or this chapter."

Renumber: subsequent sections

5. Page 28, line 2.
Following: line 1

EXHIBIT 7
DATE 3/12/93
HB 622

Insert: "(3) [Sections 24 and 25] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 24 and 25]."

EXHIBIT 7
DATE 3/12/93
HB 622

EXHIBIT 8
DATE 3-12-93
HB 622

Amendments to House Bill No. 622
First Reading Copy

Requested by Rep. Ewer
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
March 11, 1993

1. Title, line 20.
Following: ";"
Insert: "INCREASING TO SEVEN THE MEMBERSHIP OF THE BOARD OF DIRECTORS OF THE STATE FUND AND INCREASING THE COMPENSATION OF MEMBERS; PROVIDING FOR A BOARD NOMINATING COMMITTEE TO SUBMIT NAMES TO THE GOVERNOR TO FILL VACANCIES ON THE BOARD;"

2. Title, line 20.
Following: "SECTIONS"
Insert: "2-15-1019,"

3. Page 17, line 18.
Strike: "terminated"
Insert: "closed"

4. Page 26, line 20.
Following: line 19
Insert: " **Section 16.** Section 2-15-1019, MCA, is amended to read:

"2-15-1019. Board of directors of the state compensation mutual insurance fund -- nominating committee --compensation. (1) There is a board of directors of the state compensation mutual insurance fund.

(2) The board is allocated to the department for administrative purposes only as prescribed in 2-15-121. However, the board may employ its own staff.

(3) The board may provide for its own office space and the office space of the state fund.

(4)(a) The board consists of ~~five~~ seven members appointed by the governor~~. The executive director of the state fund is an ex officio nonvoting member.~~

~~(5) At least three of the five members shall represent state fund policyholders and may be employees of state fund policyholders. At least three members of the board shall represent private, for-profit enterprises. A member of the board may not:~~

~~(a) represent or be an employee of an insurance company that is licensed to transact workers' compensation insurance under compensation plan No. 2; or~~

~~(b) be an employee of a self-insured employer under compensation plan No. 1.~~ as follows:

(b) A board nominating committee of five members consisting of the speaker and the minority floor leader of the Montana house of representatives, the president and the minority leader of the Montana senate, and the insurance commissioner shall submit to

the governor a list of nominees including at least twice as many names as there are vacancies on the board.

(c) Within 30 days of receiving the list of nominees, the governor shall appoint members, from the list of nominees submitted as provided in subsection (4)(b), to fill the vacancies on the board.

~~(6)~~(5) A member is appointed for a term of 4 years. The terms of board members must be staggered. A member of the board may serve no more than two 4-year terms. A member shall hold office until a successor is appointed and qualified.

~~(7) The members must be appointed and compensated in the same manner as members of a quasi-judicial board as provided in 2-15-124, except that the requirement that at least one member be an attorney does not apply.~~

(6) Compensation of each board member is $12,000 a year, and each member is entitled to be reimbursed for travel expenses, as provided for in 2-18-501 through 2-18-503, incurred while performing board duties.

(7) The board must adopt a business plan no later that June 30 for the next fiscal year. At a minimum, the plan must include:

(a) Specific goals for the fiscal year for financial performance. The standard for measurement of financial performances will include an evaluation of premium to surplus.

(b) Specific goals for the fiscal year for operating performance. Goals are to include, but not be limited to, specific performance standards for staff in the area of senior management, underwriting and claims administration. Goals shall, in general, maximize efficiency, economy, and equity as allowed by law.

(8) The business plan must be available by request to the general public for a fee not to exceed the actual cost of publication. However, performance goals relating to a specific employment position are confidential and not available to the public.

(9) No sooner than July 1, nor later than October 31, the board shall convene a public meeting to review the performance of the state fund, using the business plan for comparison of all the established goals and targets. The board will publish, by no later that November 30 of each year, a report to the state fund's actual performance as compared to the business plan."

Renumber: subsequent sections

Amendments to House Bill 622
First Reading Copy

EXHIBIT 9
DATE 3-12-93
HB 622

Requested by Rep. Ewer
For the Committee on Workers' Compensation

March 12, 1993

1. Page 14
Following: line 8
Insert: "**Section 7.** Section 39-71-736 is amended to read:

39-71-736. Compensation -- from what date paid. (1) (a) No compensation may be paid for the first 48 hours or 6 days' loss of wages, whichever is less, that the claimant is totally disabled and unable to work due to an injury. A claimant is eligible for compensation starting with the 7th day.

(b) However, separate benefits of medical and hospital services must be furnished from the date of injury.

(2) For the purpose of this section, except as provided in (3), an injured worker is not considered to be entitled to compensation benefits if the worker is receiving sick leave benefits, except that each day for which the worker elects to receive sick leave counts 1 day toward the 6-day waiting period.

(3) Augmentation of temporary total disability benefits with sick leave by an employer pursuant to a collective bargaining agreement shall not disqualify a worker from receiving temporary total disability benefits.

(4) Receipt of vacation leave by an injured worker shall not affect the worker's eligibility for temporary total disability benefits."

Renumber: subsequent sections

HOUSE SELECT COMMITTEE REPORT

March 13, 1993

Mr. Speaker: We, the select committee on Workers' Compensation recommend that House Bill 622 (first reading copy -- white) do pass as amended, and that the House refer the bill as amended to its committee on Labor and Employment Relations for consideration as part of the Workers' Compensation package.

Signed: _____
Chase Hibbard, Chair

And, that such amendments read:

1. Title, lines 12 through 14.
Following: "INFIRMITY;" on line 12
Strike: the remainder of line 12 through line 14 in their entirety

2. Title, lines 17 through 19.
Following: "BENEFITS;" on line 17
Strike: the remainder of line 17 through "HIRING;" on line 19

3. Title, line 20.
Following: "SELF-INSURE;"
Insert: "ALLOWING CERTAIN OPTIONAL DEDUCTIBLES TO POLICYHOLDERS; REQUIRING SUSPENSION, REVOCATION, OR DENIAL OF A PROFESSIONAL OR OCCUPATIONAL LICENSE FOR VIOLATION OF THE WORKERS' COMPENSATION LAW; REVISING THE DEFINITION OF UNPROFESSIONAL CONDUCT; PROHIBITING CERTAIN ACTIONS; PRECLUDING LIABILITY FOR REPORTING VIOLATIONS OF THE WORKERS' COMPENSATION LAW; ALLOWING AUGMENTATION OF TEMPORARY TOTAL DISABILITY BENEFITS WITH SICK LEAVE AND VACATION LEAVE; REQUIRING THE STATE FUND BOARD TO ADOPT AN ANNUAL BUSINESS PLAN;"

4. Title, line 20.
Following: "SECTIONS"
Insert: "37-1-131, 37-3-322, 37-6-310, 37-10-311, 37-12-321, 37-14-321,"

Committee Vote:
Yes 6, No 0.

14. Page 19, line 4.
Following: "plan"
Insert: "and are not subject to the lump-sum payment provisions of 39-71-741"

15. Page 19, line 20.
Following: "the job"
Insert: "held at the time of injury"

16. Page 20, line 6.
Following: "of"
Strike: the remainder of line 6
Insert: "the services and benefits available"

17. Page 20, lines 7 and 8.
Following: "to" on line 7
Strike: the remainder of line 7 through "section"
Insert: "the vocational rehabilitation provisions of the Workers' Compensation Act"

18. Page 20, lines 9 through 15.
Strike: subsections (8) and (9) in their entirety

19. Page 21, line 2.
Strike: "an attending"
Insert: "a treating"
Following: "physician"
Strike: the remainder of line 2

20. Page 21, line 18 through page 23, line 15.
Strike: sections 10 through 12 in their entirety
Renumber: subsequent sections

21. Page 25, lines 14 and 15.
Following: "worker" on line 14
Strike: "is medically"
Insert: "has a physical restriction, as determined by objective medical findings, and is"
Strike: "the same," on line 14
Insert: "a"
Following: "modified" on line 15
Strike: ","

22. Page 25, line 21.
Strike: "hourly"
Insert: "average weekly"

23. Page 25, line 24.
Following: "disabled"
Insert: ", not to exceed the state's average weekly wage at the time of injury"

24. Page 26, lines 1 through 8.
Following: "weeks" on line 1
Strike: the remainder of line 1 through line 8
Insert: ".

(4) A worker requalifies for temporary total disability benefits if the modified position is no longer available to the worker and the worker continues to be temporarily totally disabled as defined in 39-71-116."

25. Page 26, lines 14 through 19.
Strike: section 15 in its entirety
Renumber: subsequent sections

26. Page 27, page 16 and 17.
Strike: section 17 in its entirety
Insert: "NEW SECTION. Section 11. Workers' compensation and employers' liability insurance -- optional deductibles. (1) An insurer issuing a workers' compensation or an employer's liability insurance policy may offer to the policyholder, as part of the policy or by endorsement, optional deductibles for benefits payable under the policy consistent with the standards contained in subsection (3).

(2) A rating organization may develop and file a deductible plan or plans on behalf of its members consistent with the standards contained in subsection (3).

(3) The commissioner of insurance shall approve a deductible plan that is in accordance with the following standards:

(a) Claimants' rights are properly protected and claimants' benefits are paid without regard to the deductible.

(b) Premium reductions reflect the type and level of the deductible, consistent with accepted actuarial standards.

(c) Premium reductions for deductibles are determined before application of any experience modification, premium surcharge, or premium discount.

(d) Recognition is given to policyholder characteristics, including but not limited to size, financial capabilities, nature of activities, and number of employees.

(e) The policyholder is liable to the insurer for the deductible amount in regard to benefits paid for compensable claims.

(f) The insurer pays all of the deductible amount applicable to a compensable claim to the person or provider entitled to benefits and then seeks reimbursement from the

board determines, after a hearing as provided in subsection (2), is guilty of knowingly defrauding, abusing, or aiding in the defrauding or abusing of the workers' compensation system in violation of the provisions of Title 39, chapter 71 or 72;

~~(3)~~(4) pay to the department its pro rata share of the assessed costs of the department under 37-1-101(6);

~~(4)~~(5) consult with the department before the board initiates a program expansion, under existing legislation, to determine if the board has adequate money and appropriation authority to fully pay all costs associated with the proposed program expansion. The board may not expand a program if the board does not have adequate money and appropriation authority available."

Section 14. Section 37-3-322, MCA, is amended to read:

"37-3-322. Unprofessional conduct. As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or in securing a license or in taking the examination provided for in this chapter;

(2) performing abortion contrary to law;

(3) obtaining a fee or other compensation, either directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition of a person can be cured;

(4) employing abusive billing practices;

(5) directly or indirectly giving or receiving a fee, commission, rebate, or other compensation for professional services not actually rendered. This prohibition does not preclude the legal functioning of lawful professional partnerships, corporations, or associations.

(6) willful disobedience of the rules of the board;

(7) conviction of an offense involving moral turpitude or conviction of a felony involving moral turpitude, and the judgment of the conviction, unless pending on appeal, is conclusive evidence of unprofessional conduct;

(8) commission of an act of sexual abuse, misconduct, or exploitation related to the licensee's practice of medicine;

(9) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors, otherwise than in the course of legitimate or reputable professional practice;

(10) conviction or violation of a federal or state law regulating the possession, distribution, or use of a narcotic or hallucinatory drug, as defined by the federal food and drug administration, and the judgment of conviction, unless pending on appeal, is conclusive evidence of unprofessional conduct;

(11) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other drug or substance to the extent that the use impairs the user physically or mentally;

(12) conduct unbecoming a person licensed to practice medicine or detrimental to the best interests of the public as defined by rule of the board;

(13) conduct likely to deceive, defraud, or harm the public;

(14) making a false or misleading statement regarding the licensee's skill or the effectiveness or value of the medicine, treatment, or remedy prescribed by the licensee or at the licensee's direction in the treatment of a disease or other condition of the body or mind;

(15) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(16) use of a false, fraudulent, or deceptive statement in any document connected with the practice of medicine;

(17) practicing medicine under a false or assumed name;

(18) testifying in court on a contingency basis;

(19) conspiring to misrepresent or willfully misrepresenting medical conditions improperly to increase or decrease a settlement, award, verdict, or judgment;

(20) aiding or abetting in the practice of medicine by a person not licensed to practice medicine or a person whose license to practice medicine is suspended;

(21) allowing another person or organization to use the licensee's license to practice medicine;

(22) malpractice or negligent practice;

(23) except as provided in this subsection, practicing medicine as the partner, agent, or employee of or in joint venture with a person who does not hold a license to practice medicine within this state; however, this does not prohibit:

(a) the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4;

(b) a single consultation with or a single treatment by a person or persons licensed to practice medicine and surgery in another state or territory of the United States or foreign country; or

(c) practicing medicine as the partner, agent, or employee of or in joint venture with a hospital, medical assistance facility, or other licensed health care provider. However:

(i) the partnership, agency, employment, or joint venture must be evidenced by a written agreement containing language to the effect that the relationship created by the agreement may not affect the exercise of the physician's independent judgment in the practice of medicine;

(ii) the physician's independent judgment in the practice of medicine must in fact be unaffected by the relationship; and

(iii) the physician may not be required to refer any patient

to a particular provider or supplier or take any other action the physician determines not to be in the patient's best interest.

(24) willfully or negligently violating the confidentiality between physician and patient, except as required by law;

(25) failing to report to the board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

(26) failing to transfer pertinent and necessary medical records to another physician when requested to do so by the subject patient or by the patient's legally designated representative;

(27) failing to furnish to the board or its investigators or representatives information legally requested by the board;

(28) failing to cooperate with a lawful investigation conducted by the board;

(29) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate parts 1 through 3 of this chapter or the rules authorized by them;

(30) having been subject to disciplinary action of another state or jurisdiction against a license or other authorization to practice medicine, based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section. A certified copy of the record of the action taken by the other state or jurisdiction is evidence of unprofessional conduct.

(31) any other act, whether specifically enumerated or not, which, in fact, constitutes unprofessional conduct."

Section 15. Section 37-6-310, MCA, is amended to read:

"37-6-310. Unprofessional conduct. As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or in securing a license or in taking the examination provided for in this chapter;

(2) obtaining a fee or other compensation, either directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition of a person can be cured;

(3) willful disobedience of the rules of the board;

(4) final conviction of an offense involving moral turpitude;

(5) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors, otherwise than in the course of legitimate or reputable professional practice;

(6) final conviction of a violation of a federal or state law regulating the possession, distribution, or use of a narcotic or hallucinatory drug, as defined by the federal food and drug

administration;

(7) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other drug or substance to the extent that the use impairs the user physically or mentally;

(8) conduct unbecoming a person licensed to practice podiatry or detrimental to the best interest of the public;

(9) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(10) testifying in court on a contingency basis;

(11) conspiring to misrepresent or willfully misrepresenting medical conditions to increase or decrease a settlement, award, verdict, or judgment;

(12) aiding or abetting in the practice of medicine a person not licensed to practice medicine or a person whose license to practice medicine is suspended;

(13) gross malpractice or negligent practice;

(14) practicing podiatry as the partner, agent, or employee of or in joint venture with a person who does not hold a license to practice podiatry within this state; however, this does not prohibit the incorporation of an individual licensee or group of licensees as a professional service corporation under Title 35, chapter 4, nor does this apply to a single consultation with or a single treatment by a person or persons licensed to practice podiatry in another state or territory of the United States or foreign country;

(15) violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of or conspiring to violate parts 1 through 3 of this chapter or the rules authorized by parts 1 through 3; or

(16) any other act, whether specifically enumerated or not, which in fact constitutes unprofessional conduct."

Section 16. Section 37-10-311, MCA, is amended to read:

"37-10-311. Revocation -- unprofessional conduct. (1) The board may revoke a certificate of registration for:

(a) physical or mental incompetence;

(b) gross malpractice or repeated malpractice;

(c) a violation of any of the provisions of this chapter or rules or orders of the board; or

(d) unprofessional conduct.

(2) Unprofessional conduct includes:

(a) obtaining a fee by fraud or misrepresentation;

(b) employing, directly or indirectly, a suspended or unlicensed optometrist to perform work covered by this chapter;

(c) directly or indirectly accepting employment to practice optometry from a person not having a valid certificate of

registration as an optometrist or accepting employment to practice optometry for or from a company or corporation;

(d) permitting another to use ~~his~~ the optometrists's certificate of registration;

(e) soliciting or sending a solicitor from house to house;

(f) treatment or advice in which untruthful or improbable statements are made;

(g) professing to cure nonocular disease;

(h) advertising in which ambiguous or misleading statements are made; ~~or~~

(i) the use in advertising of the expression "eye specialist" or "specialist on eyes" in connection with the name of an optometrist. This chapter does not prohibit legitimate or truthful advertising by a registered optometrist; or

(j) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or a claim for benefits under Title 39, chapter 71 or 72.

(3) Before a certificate is revoked, the holder shall be given a notice and an opportunity for a hearing.

(4) Any optometrist convicted a second time for violation of the provisions of this chapter or whose certificate of registration or examination has been revoked a second time shall not be permitted to practice optometry in this state."

Section 17. Section 37-12-321, MCA, is amended to read:

"37-12-321. Unprofessional conduct. As used in this chapter, "unprofessional conduct" means:

(1) resorting to fraud, misrepresentation, or deception in applying for or securing a license or in taking the examination provided for in this chapter;

(2) obtaining any form of compensation, directly or indirectly, by the misrepresentation that a manifestly incurable disease, injury, or condition can be cured;

(3) practicing chiropractic under a false or assumed name or impersonating another practitioner of like or different name;

(4) knowingly disobeying a rule of the board;

(5) conviction of a criminal offense involving moral turpitude. A certified copy of the judgment of conviction is conclusive evidence of the conviction. This subsection is subject to chapter 1, part 2, of this title.

(6) habitual intemperance or excessive use of narcotic drugs, alcohol, or any other substance to the extent that such use impairs the user's physical or mental professional capability;

(7) administering, dispensing, or prescribing a narcotic or hallucinatory drug, as defined by the federal food and drug administration or successors;

(8) resorting to fraud, misrepresentation, or deception in the examination or treatment of a person or in billing or reporting to a person, company, institution, or organization, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72;

(9) testifying in court on a contingency basis;

(10) conspiring to misrepresent or knowingly misrepresenting physical conditions in order to increase or decrease a settlement or award;

(11) aiding or abetting in the practice of chiropractic a person not licensed to practice chiropractic or a person whose license is suspended;

(12) practicing chiropractic as the partner, agent, or employee of or in joint venture with a person not licensed to practice chiropractic in this state. However, this does not prohibit incorporation as a professional service corporation under Title 35, chapter 4, or prevent a single consultation with or a single treatment by a person licensed to practice chiropractic in another state or territory of the United States or a foreign country.

(13) violating, attempting or conspiring to violate, or aiding or abetting in the violation of this chapter or the rules adopted under it; or

(14) conduct unbecoming a person licensed to practice chiropractic or detrimental to the best interests of the public."

Section 18. Section 37-14-321, MCA, is amended to read:

"37-14-321. Revocation or suspension of license or permit. A license or permit may be suspended for a fixed period or may be revoked, or such technologist or technician may be censured, reprimanded, or otherwise disciplined as determined by the board if, after a hearing before the board, it is determined that the radiologic technologist or limited permit technician:

(1) is guilty of fraud or deceit in activities as a radiologic technologist or limited permit technician or has been guilty of any fraud or deceit in procuring the license or permit;

(2) has been convicted in a court of competent jurisdiction of a crime involving moral turpitude;

(3) is an habitual drunkard or is addicted to the use of narcotics or other drugs having a similar effect or is not mentally competent;

(4) is guilty of unethical or unprofessional conduct, as defined by rules promulgated by the board, including fraud, misrepresentation, or deception with regard to a claim for benefits under Title 39, chapter 71 or 72, or has been guilty of incompetence or negligence in ~~his~~ activities as a radiologic technologist or limited permit technician;

(5) has continued to perform as a radiologic technologist or limited permit technician without obtaining a license or

permit or renewal as required by this chapter."

NEW SECTION. Section 19. Prohibited actions -- penalty. (1) The following actions by a medical provider constitute violations and are subject to the penalty in subsection (3):

(a) failing to document, under oath, the provision of the services or treatment for which compensation is claimed under chapter 72 or this chapter; or

(b) referring a worker for treatment or diagnosis of an injury or illness that is compensable under chapter 72 or this chapter to a facility owned wholly or in part by the provider, unless the provider informs the worker of the ownership interest and provides the name and address of alternate facilities, if any exist.

(2) A person licensed to practice law in Montana or a medical care provider who advertises services or facilities with the intention that a worker use those services or facilities with regard to an injury or illness that is compensable under chapter 72 or this chapter and who fails to announce in the advertisement that filing a fraudulent claim is theft, as provided in 39-71-316, is subject to the penalty in subsection (3).

(3) A person who violates this section may be assessed a penalty of not less than $200 or more that $500 for each offense. The department shall assess and collect the penalty.

NEW SECTION. Section 20. No liability for reporting violation. A person, including but not limited to an insurer or an employer, may not be held liable for civil damages as a result of reporting in good faith information that the person believes proves a violation of the provisions of chapter 72 or this chapter.

Section 21. Section 39-71-736, MCA, is amended to read:

"39-71-736. Compensation -- from what date paid. (1) (a) No compensation may be paid for the first 48 hours or 6 days' loss of wages, whichever is less, that the claimant is totally disabled and unable to work due to an injury. A claimant is eligible for compensation starting with the 7th day.

(b) However, separate benefits of medical and hospital services must be furnished from the date of injury.

(2) For the purpose of this section, except as provided in subsection (3), an injured worker is not considered to be entitled to compensation benefits if the worker is receiving sick leave benefits, except that each day for which the worker elects to receive sick leave counts 1 day toward the 6-day waiting period.

(3) Augmentation of temporary total disability benefits with sick leave by an employer pursuant to a collective

bargaining agreement may not disqualify a worker from receiving temporary total disability benefits.

(4) Receipt of vacation leave by an injured worker may not affect the worker's eligibility for temporary total disability benefits."

Section 22. Section 39-71-2315, MCA, is amended to read:

"39-71-2315. Management of state fund -- powers and duties of the board -- business plan required. (1) The management and control of the state fund is vested solely in the board.

(2) The board is vested with full power, authority, and jurisdiction over the state fund. The board may perform all acts necessary or convenient in the exercise of any power, authority, or jurisdiction over the state fund, either in the administration of the state fund or in connection with the insurance business to be carried on under the provisions of this part, as fully and completely as the governing body of a private mutual insurance carrier, in order to fulfill the objectives and intent of this part. Bonds may not be issued by the board, the state fund, or the executive director.

(3) The board shall adopt a business plan no later than June 30 for the next fiscal year. At a minimum, the plan must include:

(a) specific goals for the fiscal year for financial performance. The standard for measurement of financial performances must include an evaluation of premium to surplus.

(b) specific goals for the fiscal year for operating performance. Goals must include but not be limited to specific performance standards for staff in the area of senior management, underwriting, and claims administration. Goals must, in general, maximize efficiency, economy, and equity as allowed by law.

(4) The business plan must be available upon request to the general public for a fee not to exceed the actual cost of publication. However, performance goals relating to a specific employment position are confidential and not available to the public.

(5) No sooner than July 1 or later than October 31, the board shall convene a public meeting to review the performance of the state fund, using the business plan for comparison of all the established goals and targets. The board shall publish, by November 30 of each year, a report of the state fund's actual performance as compared to the business plan.""

Renumber: subsequent section

27. Page 27, lines 18 through 23.
Following: "(1)" on line 18
Strike: the remainder of subsection (1) in its entirety through "14]" on line 23
Insert: "[Sections 8 and 9]"

28. Page 28, line 1.
Strike: "[sections 13 and 14]."
Insert: "[sections 8 and 9].
(2) [Section 11] is intended to be codified as an integral part of Title 39, chapter 71, part 4, and the provisions of Title 39, chapter 71, part 4, apply to [section 11].
(3) [Sections 19 and 20] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 19 and 20]."

29. Page 28, line 2.
Following: line 1
Insert: "NEW SECTION. Section 24. Severability. If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

NEW SECTION. Section 25. Effective date. [This act] is effective July 1, 1993."

- BILL NO - REFERRED - HEARING - OTHER CONSIDERATION DATES - EXECUTIVE ACTION/DATE/VOTE ------- REREFERRED ---- DATE READ

HB0526	BRANDEWIE, RAY		REQUIRE RELEASE OF CERTAIN DEPT OF SRS & DEPT OF REV INFO TO DEPT OF LABOR					
	2/08	2/11		PASS AS AMENDED	2/11	VOTE: 13-3		2/13
HB0569	RUSSELL, ANGELA		ESTABLISHING PENALTY FOR VIOLATING INDIAN HIRING PREFERENCE LAWS					
	2/10	2/16		TABLED ON	02/16	VOTE: 9-7		
HB0578	SQUIRES, CAROLYN		DEFINE REPETITIVE MOTION INJURY AS INJURY UNDER WORKERS' COMPENSATION ACT					
	2/10	2/16		TABLED ON	02/16	VOTE: 9-7		
HB0580	COCCHIARELLA, VICKI		REVISING LUMP-SUM SICK LEAVE PAYMENTS WHEN EMPLOYEES TERMINATE EMPLOYMENT					
	2/10	2/16		TABLED ON	02/16	VOTE: 16-0		
HB0587	HARPER, HAL		REVISE WORK COMP CLASSIFICATION AND RATING COMMITTEE PROVISIONS					
	3/11	3/16		DO PASS	3/18	VOTE: 16-0		3/20
HB0617	GRADY, ED		FEDERALLY CERTIFIED PRISON INDUSTRIES PROGRAM					
	2/13	2/16		PASS AS AMENDED	2/16	VOTE: 16-0		2/17
HB0621	ELLIOTT, JIM		REVISE RECOGNIZING DIFFERENT PAY RATES FOR CONSTR. IND. WORK COMP INS. RATE					
	2/13	2/16		DO PASS	2/16	VOTE: 16-0		2/17
HB0622	EWER, DAVID		GENERALLY REVISE WORK COMP AND OCCUPATIONAL DISEASE LAWS					
	3/13	3/16		PASS AS AMENDED	3/18	VOTE: 15-1		3/20
HB0628	TOOLE, HOWARD		CARE MANAGEMENT/BUDGETING FOR WORK COMP; CREATE MEDICAL PROCEDURES AUTH. COM					
	3/11	3/16		PASS AS AMENDED	3/18	VOTE: 16-0		3/20
HB0630	TUSS, CARLEY		RAISE MINIMUM WAGE TO $5.50/HOUR AND INDEX FUTURE INCREASES TO FEDERAL WAGE					
	2/15	2/18		TABLED ON	02/18	VOTE: 9-7		
HJ0016	QUILICI, JOE		RESOLUTION URGING NATIONAL DESIGNATION FOR BUTTE-ANACONDA AREA					
	2/10	2/16		DO PASS	2/16	VOTE: 16-0		2/17
	DOHERTY, STEVE		UNEMPLOYMENT BENEFITS EXCLUSION FOR EMPLOYER ORDERED TO ACTIVE DUTY					
				CONCUR	2/11	VOTE: 16-0		2/13

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON LABOR & EMPLOYMENT RELATIONS

Call to Order: By Chairman Tom Nelson, on March 16, 1993, at 3:00 p.m.

ROLL CALL

Members Present:

Rep. Tom Nelson, Chair (R)
Rep. Gary Feland, Vice Chair (R)
Rep. Steve Benedict (R)
Rep. Vicki Cocchiarella (D)
Rep. Jerry Driscoll (D)
Rep. Alvin Ellis (R)
Rep. Pat Galvin (D)
Rep. Sonny Hanson (R)
Rep. Norm Mills (R)
Rep. Bob Pavlovich (D)
Rep. Bruce Simon (R)
Rep. Carolyn Squires (D)
Rep. Bill Tash (R)
Rep. Rolph Tunby (R)
Rep. Carley Tuss (D)
Rep. Tim Whalen (D)

Members Excused: None

Members Absent: None

Staff Present: Susan Fox, Legislative Council
Cherri Schmaus, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 361, HB 622, SB 347, HB 628, SB 163, SB 164, HB 453, SB 394, HB 504, HB 13, HB 511 & HB 587
Executive Action: None

PACKAGE OF BILLS FROM THE SELECT COMMITTEE ON WORKERS COMP

Opening Statement by Sponsor:

REP. CHASE HIBBARD, HD 46, Lewis and Clark County, sponsor,

opened the hearing by handing out an outline of the bills to be presented and the order of their presentation. **EXHIBIT #1** He told the committee and the audience that the intent of the Workers' Compensation Select Committee was to have a non-partisan committee with three republicans and three democrats. He stated that everyone gives including employers and insurers. The package includes provisions for fraud, safety and a data base for lawyers and medical providers. The intent of this package of bills is to provide solutions to today's problems. He presented the committee with a outline for the major areas of reform **(EXHIBIT #2)**

HB 361

REP. HIBBARD stated that this bill contains key components to reform benefits and medical definitions under workers' compensation laws. This bill was modeled after a similar bill in Oregon state. The focus of HB 361 is access of benefits, rather than reduction. Furthermore, this bill redefines injury. Pain is no longer compensable. A heart attack and stroke are considered an injury. Benefits are only paid if the major contributing factor is due to the injury. For example, if alcohol and drugs are the major contributing factor, that individual is not covered or compensable.

HB 622

REP. HIBBARD stated that this bill is a catch all bill. The intent of this bill is to encourage early return to work and to create temporary partial benefits. Medical benefits are available to the worker unless these benefits are not used for a period of 60 months.

SB 347

REP. HIBBARD stated that the intent of this bill is to deliver timely and effective care for injured workers. Submanagement care must be referred to a specialist. This bill encourages insurers to provide preferred providers. The Department of Labor plays a neutral role. Hospital rates reimburse at the same rate as Medicare, but not less than their current rates. The passage of this bill will limit domiciliary care to eight hours per day. He told the committee to consider this bill very carefully because it is essential to control medical costs.

HB 628

REP. HIBBARD stated that the intent of this bill is to provide managed care for workers' compensation and limit the choice of physicians. This bill deals with more severe injuries than HB 347. He urged the committee to consider not implementing this bill.

SB 163

REP. HIBBARD stated that this bill will prevent injuries before they occur and will focus on safety. A business with five or more employees will be required to establish a safety committee and a Line of Duty (LOD) procedure. Furthermore, this bill will provide student safety awareness training before these students enter the work force full-time. **REP. HIBBARD** stated that the passage of this bill is very important to the package.

SB 164

REP. HIBBARD stated that this bill deals with prevention. The purpose of SB 164 is to create a fraud investigation office in the Department of Justice and a prevention of fraud office at the State Fund. This bill will allow the State Fund to send the message that fraud won't be tolerated and to give them the tools they need to enforce fraud provisions.

HB 453

REP. HIBBARD stated that this bill complements the fraud provisions in SB 164. The passage of this bill will make thieves pay ten times the amount that would be paid by an insurer on the false claim..

HB 622

REP. HIBBARD stated that this bill is a catch-all bill. The purpose of the bill is to generally revise workers' compensation and occupational disease laws. Everyone is subject to the same rules under this bill. A lawyer who does not pay will be charged with fraud.

SB 394

REP. HIBBARD stated that the passage of this bill will regulate attorney fees for workers' compensation cases.

HB 504

REP. HIBBARD stated that the passage of this bill is necessary to get out from under the problems in workers' compensation more quickly. This bill increases the payroll tax and imposes an employee wage tax to eliminate the old fund unfunded liability.

HB 13

REP. HIBBARD stated that the purpose of this bill is to generally revise workers' compensation laws and to revise the State Fund's budget and funding procedures. The passage of this bill makes sure all findings are reported to the Governor.

HB 511

REP. HIBBARD stated that the purpose of HB 511 is to create a workers' compensation database system to compile management information on the system. The passage of this bill will include plan 1 and 2 carriers, and State Fund.

HB 587

REP. HIBBARD stated that the passage of this bill will revise workers' compensation classification and rating committee provisions.

Proponents' Testimony:

REP. STEVE BENEDICT stated that he was the vice chairman on the Workers' Compensation Select Committee. He passed out amendments on HB 13 **(EXHIBIT #3)**. He stated that he supports the recommendations of **REP. HIBBARD**. He stated that the proposed amendments make the bill more clear to the public. Furthermore, the passage of this bill (with the amendments) will put the State Fund in a better position and allow the Governor to authorize privatization.

He stated that HB 504 allows the old fund to borrow from the new fund premiums.

REP. EWER, HD 45, commended the select committee on all of their hard work. He stated his concern with privatization. He urged the committee to make careful consideration when changing the package because everyone wants the package to get through.

Rose Hughes, Executive Secretary of the Montana Health Care Association, stated that her organization supports HB 13 with the purposed amendments.

She stated that she is concerned with HB 511 because her organization feels that Montana doesn't have the same information as the other states.

She referred to the outline and stated that this package covers all the necessary subjects dealing with workers' compensation.

Rick Hill, Governor's Office, stated that he is testifying on behalf of Governor Racicot. The Governor feels that workers' compensation is one of the most important issues confronting Montana today. He stated that most of the bills in this package were requested by the Governor and he is prepared to help the State Fund anyway possible.

Beth Baker, Department of Justice, stated that the passage of SB 164 will add three new positions for fraud investigation. This bill will also help stop the abuse of workers' compensation. She stated that her organization would like to be on the record in support of SB 164.

George Wood, Executive Secretary of the Montana Self Insurance Association, stated that his organization is opposed to HB 504 because of the payroll tax.
He stated his concern with HB 511's cost to the Department of Labor. Furthermore, he stated that stress is a great concern in the United States, but it is hard to categorize stressful situations that will reflect on workers.

He stated that HB 622 needs to be clarified dealing with temporary partial disability benefits. Presently the way the bill is drafted, temporary partial disability claims would receive more than total disability claims.

Don Allen, Coalition of Workers' Compensation System Improvement, stated that there are 215 businesses and organizations in the coalition. Several of them felt that bringing concepts together would help resolve the workers' compensation problems. He stated that his organization does not take a stand on HB 13, but has a strong endorsement on HB's 631, 622, and SB's 163, 164, 347, and 394.

Terry Mitton, Coalition of Workers' Compensation System Improvement, stated that prescription drugs need some control. Furthermore, Montana needs to follow the national standards on managed care. She stated that injured workers want to expedite their return to work. Compliance with medical treatment is necessary. If the patients don't make their appointments, the Department won't work with them.

Pat Sweeney, State Fund, stated that his organization generally supports the entire package of bills because it gives the tools to control the costs in workers' compensation.

Mike Micone, Montana Motor Carriers, stated that rates for motorists have increased and will continue to increase to a double digit number. He proposed an amendment so that several small carriers can combine into a group to get policies as a group and receive some cost reduction. Furthermore, this may encourage private carriers also to set up policies in this state.

Riley Johnson, National Federation of Independent Businesses, stated that HB 511 needs to be researched more. Computers will save time, but cost millions.

He stated that 80 percent of his members don't want payroll tax.

He stated that he supports HB 361 and HB 622 as well as the four bill's sponsored by **SEN. HARP**.

He stated that his organization had several concerns with HB 13; however, with the amendments, they support it. His organization has a 90 percent favoritism for privatization. He stated that an amendment needs to be proposed to support the small businesses.

Russ Logan, Billings Chamber of Commerce, stated that he supports the package and understands the give and take; however, he thinks it is a necessity to make sure the new fund is financially liable in HB 504.

He stated that SB 347 excludes those in the medical community.

James Tutwiler, Chamber of Commerce, stated that he supports the following bills: HB 13 with the amendments, HB 361, HB 622, SB 163, SB 164, and SB 347.

He stated that his organization is opposed to HB 504 because of the payroll tax.

Paul Spetanka, Podiatric Medical Association, stated that his organization supports medical cost containment in HB 347 and HB 628; however, he suggested that podiatrists be considered physicians.

Charles Brooks, Montana Retail Association, stated that perception is 90 percent of reality. Currently there are 6 workers' compensation cases in the court that can't proceed with prosecution because of the poor condition they are in.

Oliver Goe, attorney, commended the select committee and their accomplishments. He stated that HB 361 clarifies who, when and where an individual will qualify for workers' compensation.

He stated that HB 622 clarifies, provides and insures employers rights under the Workers' Compensation Act.

He stated that safety is an important issue; however, his concern is with the potential costs.

He stated that SB 164 affects all insurers.

Insurers can use SB 347 as a tool to handle the increased medical costs.

He stated that he is opposed to HB 511 because it needs added clarification as to what to do with the money.

He stated that HB 628 is a good bill, but he is curious how it will fit in with SB 374.

Bill Prevella, Rehabilitation Association of Montana, stated that his organization's goal this session is to keep workers properly informed. He stated that honesty to employees will make them return to work more quickly.

Mona Jameson, PT Association, stated that her organization supports HB 13 with the proposed amendments. HB 13 will improve the operation of the State Fund.

She stated that her organization would like to see physical therapists included in the scope of the bill and placed in the health loop as a provider.

Gary Lusane, a physical therapist in Bozeman, stated that his organization supports SB 163, SB 164 and HB 511.

Jerome Connolly, Montana Chamber American Physical Therapist Association and a physical therapist in Billings, stated that he supports the package, especially HB 622 because it will return employees to work faster.

Jamey Doggett, Montana Cattlewomen, stated that her organization supports HB's 13, 511, 622, 361 and SB's 163, 164, and 394.

Jacqueline Lenmark, American Insurance Association, stated that her organization supports the package, but has a concern with SB 347 dealing with rural workers and emergency care.

Keith Olsen, Executive Officer of Montana Logging Association, stated that his organization supports Senator Harp's bills. He stated that today it is cost versus value. This package may provide a competitive advantage for Montana.

Harley Thompson, Building Industry Association, stated that his organization supports SB's 163, 164, 347 and HB's 361 and 622. He stated that they feel that this package will repair the mess that workers' compensation is in at the current time.

Mark Sonyu, Workers' Compensation System Improvement, stated that his organization supports the package.

Russ Ritter, Washington Corporation, stated that there are 3,000 employees in his company. All of these employees are covered under this system except about 800 Rail Link employees.

Sam Hubbard, Deaconess Medical Hospital in Billings, stated that his organization is in support of SB 347 because of the medical cost containment.

Bob Olsen, Montana Hospital Association, stated that his organization supports HB 511 and all of the fraud bills.

Leslie Ranch, General Well service, (EXHIBIT #4).

Tom Arvidson (EXHIBIT #5).

Edsall Construction (EXHIBIT #6).

Dolphin Harris, President of Sidney Millwork Company (EXHIBIT #7).

Ardine (Dean) Bjerke (EXHIBIT #8).

Harley Thompson, Montana Building Industry Association to the Coalition for Workers Compensation System Improvement (CWCSI), (EXHIBIT #9).

Michael Mizenko, Montana State Association of Plumbers and Pipe Fillers and Montana State Building and Construction Council, (EXHIBIT #10).

Opponents' Testimony:

Dan Edward, Oil Chemical Workers' Union, provided the committee with a handout called titled "OCAN". **(EXHIBIT #18)** He stated that not all employees who are hurt on the job are involved in fraud. Most of employees are honest and hard working. He stated that his biggest concern is with the language that provides secondary medical services on returning employees back to work. He asked who decides what is cost effective? He stated that the passage of these bills may be hurting those who need the most help.

Don Judge, Montana AFL-CIO, stated that his organization is opposed to HB's 361 and 504 and SB's 347 and 394. Furthermore, his organization supports HB's 511, 622, 628 and SB 163.

He stated that his concern with HB 361 is that it limits workers benefits, on one part of the body, to 350 weeks rather than an entire lifetime.

He stated that HB 511 is a good bill and he believed it would help correct the problems by providing the information needed in order to make decisions.

He stated that SB 347 is the worst bill in the package because if an employee is seriously hurt on the job, they are fixed and that is the extent of their coverage. These injured employees don't receive benefits for emotional stress or anything that may arise at a later date, due to the accident.

He stated that SB 394 limits attorney fees and should be listed under cost containment. Furthermore, it limits benefits to injured workers, not costs. He urged the committee to vote on this bill separately and not part of the package.

John Alke, Montana Defense Lawyers, stated that his interest deals with the amendment on SB 394. Capping the money insurers can pay their counsel is unreasonable because currently there is no limit for the defense. He asked how workers' compensation will be served after 100 hours of work is performed and the lawyer must stop.

John Malee, Montana Federation of Teachers and State Employees, stated that his organization is opposed to the package on workers' compensation.

Russell Hill, Montana Trial Lawyers, stated that HB 361 provides potential for added costs.

He stated that SB 164 will provide a new risk and burden to employees. He provided the committee with several handouts. **(EXHIBITS # 11, 12, 13, 14, AND 15)**

Dan Shea, self, provided the committee with written testimony. **(EXHIBIT # 16 AND #19).** He stated that the working poor are the majority of the work force and he feels they are not represented in this legislation. He asked where the money comes from for the necessary visits to their physicians. He stated that these employees fall into a catch 22 situation. He referred to the letter he provided the committee and stated that it provides solutions of how to deal with this situation. These people are denied equal protection of the law and can't afford the co-payments. He stated that if the attorney fees are capped, the defense also needs a cap. If this cap does not occur, defense will wait until the attorney is no longer on the case and win the case. Furthermore, the number for this cap seems to be picked out of a hat with no rationale behind it. He stated that if they put a cap on medical, everyone would be out of time.

Lars Erickson, Montana State Council for Carpenters, stated that his organization supports HB's 511, 622, 628 and SB's 163 and 164. He stated that his organization is opposed to HB's 504, 361 and SB 394 and SB 347. He stated that SB 347 is the worst bill in the package.

Bill Egan, Conference of Electrical Workers, stated that his organization doesn't support workers' compensation in the first place because it eliminates due process. He stated that his organization is opposed to HB 504 and HB 361. Furthermore, his organization supports SB 394 if there could be caps on both sides of the fence. They also support SB 347 as amended. He stated that the baby should not be thrown out with the bath water.

Marie Gritzuk, Interdepartmental Coordinating Committee for Women (ICCW), (EXHIBIT #17).

Questions From Committee Members and Responses:

REP. DRISCOLL referred to SB 394 and asked John Alke if $7,500 is the maximum that can be spent to defend against insurance companies? Furthermore, he asked if they could still hire a staff attorney?

John Alke stated that not all workers' compensation claims are with the State Fund.

REP. DRISCOLL asked Mr. Alke if he thinks $7,500 is a good limit?

John Alke stated no.

REP. ELLIS asked George Wood what data would be relevant if the United States works with Canada on a common database?

George Wood stated that he anticipates the standards to become international.

REP. ELLIS asked Mr. Wood if the standards becomes international would his organization still have a problem supporting this bill? Furthermore, he asked if he felt there were any bases not covered or any deficiencies?

George Wood stated no, that he would strongly support it. He stated that he feels legislation is needed in this area.

REP. WHALEN asked **REP. HIBBARD** what the Labor Committee's authority is with this package.

REP. HIBBARD stated that the Labor Committee has the authority to segregate or clean up the package.

REP. WHALEN asked Russell Hill if there is room for disagreement on medical standings on HB 622 page 44 and 45, section 19.

Russell Hill stated that he sees a problem arising with the massive shift to insurance companies away from attorneys and doctors. Furthermore this shifting will create a huge grey area.

REP. WHALEN asked Mr. Connolly if health care providers can be penalized with fraud if they render the wrong opinion.

Mr. Connolly stated yes, this is a concern for many health care providers.

REP. SIMON asked Mr. Sweeney what the present capabilities are with the data base. He also asked what data would be able to be collected that can't be collected now?

Mr. Sweeney stated that they have capabilities to analyze each level of payroll. He stated that a number of things can be done now and gave an example of data sharing.

REP. SIMON asked **REP. HIBBARD** how the process would go about estimating blood alcohol and if an employee can refuse the test if they have been drinking?

REP. HIBBARD referred him to Nancy Butler with State Fund. She stated that several of the cases are accidents. If a blood alcohol is not taken, they look to see if alcohol is a major contributing factor.

REP. SIMON asked Nancy Butler how they can estimate a blood alcohol?

Nancy Butler stated that it is up to the doctor to order a blood

alcohol test if he/she believes the patient is involved with alcohol.

REP. SIMON referred to HB 13 and asked **REP. BENEDICT** because Workers' Compensation would be audited on an annual basis, if an appropriations should be added to the Legislative Auditor.

REP. BENEDICT stated that he has talked with the Legislative Auditor and they have not requested any money.

REP. MILLS asked Mr. Sweeney if his organization has a computer complex to take care of the data base?

Mr. Sweeney stated yes.

REP. MILLS asked Mr. Sweeney if this will protect fraud and repetitive injuries on the same individuals at the same time.

Mr. Sweeney stated yes, workers' compensation wants to replace and enhance the current system.

REP. ELLIS asked George Wood if he knows of any system or state that defines stress better than Montana?

George Wood stated no, everyone has a hard time defining stress.

REP. ELLIS asked **SEN. HARP** if his bill conflicts with **REP. TOOLE's** bill.

SEN. HARP stated that he thinks they will stand on their own; furthermore, he stated that his bill has already passed. The two bills can't be combined because they are very different.

REP. COCCHIARELLA asked John Shontz, MHAM, if Montana is prohibited from discrimination between physical and mental illness for coverage.

John Shontz stated that addictions and stress in themselves are not mental illnesses.

REP. BENEDICT asked John Shontz if his organization is trying to persuade the committee with his testimony?

John Shontz stated that his organization is not trying to persuade, but just to suggest that addiction and stress are not mental illnesses.

REP. DRISCOLL asked Mr. Shontz how a person's work can be responsible for manic depression.

Mr. Shontz told **REP. DRISCOLL** that a good example would be an employee who is not fed correctly and lacks necessary nutrients.

REP. DRISCOLL asked Mr. Shontz why his scenario would not be

covered under Occupational Disease. Furthermore, he asked how long this manic depression would take to occur under the scenario given.

REP. SQUIRES stated that it could be as little as two days. One of the effects could be a heart attack.

REP. SQUIRES told **REP. HIBBARD** her concern with **SEN. HARP's** bill is the length of time an individual can have coverage. She stated that patients with head injuries can become impulsive and need more than eight hours of care per day.

REP. HIBBARD stated that workers' compensation costs money and the first dollar is the insurer's dollar; therefore, there must be a limit on costs.

REP. SQUIRES asked Bob Olsen if he is comfortable with the hospital reimbursement rates.

Bob Olsen stated that yes, he is satisfied because a DRG system will be created by the Department of Labor

REP. SQUIRES asked Mr. Allen what the current Chief of the Safety Director does to encourage safety?

Mr. Allen stated that Mr. Allen has his own business in Kalispell and he sponsors several safety seminars; furthermore, he has worked with various committees dealing with safety.

REP. WHALEN asked John Connolly if HB 361 changes the standards so that the objective of the test is to find the injury, document it and then give potential treatment?

John Connolly stated yes.

REP. WHALEN asked Mr. Connelly if a soft tissue injury produces a finding on an objective test because his experiences with this are that they compare one side of the body to the other.

REP. WHALEN asked if there is a way of objectifying pain or if it is just considered a condition that exists.

REP. HIBBARD stated that the subcommittee on workers' compensation spent many hours on pain. He stated that he shares the same concern; however, these objective tests are performed by professionals. In other words, these patients can not fake their pain.

REP. WHALEN asked Mr. Sweeney if MAPA is in or out of the bill now?

Mr. Sweeney stated that MAPA is back in now. He stated that MAPA is a stumbling block; however, state fund can live under MAPA for rate-making purposes.

Closing by Sponsor:

REP. HIBBARD closed on the package by encouraging the committee to step away from where they are and not to lose the forrest in the trees. He told the committee that they had just heard the basic ingredients to repair workers' compensation. Montana is not Oregon, but with reforms Montana can use the ingredients to improve workers' compensation.

HOUSE OF REPRESENTATIVES

LABOR COMMITTEE

ROLL CALL DATE 3/16/93

NAME	PRESENT	ABSENT	EXCUSED
REP. TOM NELSON, CHAIRMAN	✓		
REP. GARY FELAND, VICE CHAIRMAN	✓		
REP. STEVE BENEDICT	✓		
REP. VICKI COCCHIARELLA	✓		
REP. JERRY DRISCOLL	✓		
REP. ALVIN ELLIS	✓		
REP. PAT GALVIN	✓		
REP. SONNY HANSON	✓		
REP. NORM MILLS	✓		
REP. BOB PAVLOVICH	✓		
REP. BRUCE SIMON	✓		
REP. CAROLYN SQUIRES	✓		
REP. BILL TASH	✓		
REP. ROLPH TUNBY	✓		
REP. CARLEY TUSS	✓		
REP. TIM WHALEN	✓		

DATE 3/16/93

HB

WC Package

WORKERS COMPENSATION PACKAGE
OUTLINE

I MAJOR AREAS OF REFORM

A. MODIFYING OR RESTRICTING ACCESS TO BENEFITS
1. HB 361 HIBBARD
2. HB 622 EWER (PARTS)

B. MEDICAL COST CONTAINMENT
1. SB 347 HARP
2. HB 628 TOOLE

C. SAFETY
1. SB 163 HARP

D. FRAUD
1. SB 164 HARP
2. HB 453 MOLNAR
3. HB 622 EWER (AMENDMENTS)

E. ATTORNEY FEES
1. SB 394 HARP

II OLD FUND PROBLEM

A. PAYING FOR THE UNFUNDED LIABILITY ($400 -426 MM)
1. HB 504 BENEDICT .05% PAYROLL TAX

III NEW FUND MANAGEMENT AND BOARD

A. HB 13 BENEDICT
B. HB 622 (AMENDMENTS)

IV SYSTEM IN GENERAL

A. HB 511 HIBBARD
B. HB 587 HARPER
C. HB 622 EWER (PARTS)

V BILLS SIGNIFICANT BUT NOT PART OF THE PACKAGE

A. HB 470 DRISCOLL - INDEPENDENT CONTRACTORS
SCHEDULED HEARING TUESDAY AT 3:00 PM IN SENATE LABOR - ALREADY PASSED HOUSE LABOR

THIS BILL REQUIRES ALL INDEPENDENT CONTRACTORS IN THE CONSTRUCTION INDUSTRY TO PURCHASE WORKER'S COMPENSATION COVERAGE, AND THEY ARE NOT ALLOWED TO EXEMPT THEMSELVES FROM COVERAGE.

ALSO PROVIDES THAT THE DEPARTMENT OF LABOR WILL PURSUE REPORTS OF UNINSURED INDEPENDENT CONTRACTORS.

B. HB 487 BRANDEWIE - CONSTITUTIONAL AMENDMENT

THIS BILL PROVIDES FOR A CONSTITUTIONAL AMENDMENT TO BE PLACED ON THE BALLOT. IT ASSERTS CONSTITUTIONALLY THE RIGHT OF THE LEGISLATURE TO ESTABLISH ELIGIBILITY FOR WORKER'S COMPENSATION BENEFITS AND SET LIMITS ON BENEFITS.

C. SB 381 FORRESTER - PENALIZE EMPLOYER FOR MIS-CLASSIFICATION

D. HB 296 DRISCOLL - RECIPROCITY BILL

THIS BILL PROVIDES THAT EMPLOYERS IN THE CONSTRUCTION INDUSTRY THAT WORK IN MONTANA, MUST PURCHASE MONTANA COVERAGE ON ALL EMPLOYEES. MONTANA WILL NO LONGER RECOGNIZE OUT-OF-STATE COVERAGE FOR NON-RESIDENTS FOR THE CONSTRUCTION INDUSTRY.

THIS BILL PUTS OUR MONTANA CONSTRUCTION INDUSTRY EMPLOYERS ON AN EQUAL FOOTING WITH OUT-OF-STATE EMPLOYERS WHO MAY BE PAYING CHEAPER WORKER'S COMPENSATION RATES.

E. SB 256 SWYSGOOD - NON RESIDENT COVERAGE (MERGED WITH HB 296 AND PASSED HOUSE LABOR) - ALLOW MONTANA EMPLOYERS WHO HAVE NON-RESIDENTS WHO DO NOT WORK IN MONTANA, SUCH AS IN THE INTERSTATE TRUCKING INDUSTRY, THE OPPORTUNITY TO ELECT COVERAGE FOR THOSE NON-RESIDENTS.

THIS PROVISION HELPS OUT OUR MONTANA BASED EMPLOYERS WHO HAVE EMPLOYEES ACROSS THE UNITED STATES.

F. HB 259 - SCHWINDEN (PASSED HOUSE -3RD READING-SENATE - 3/12/93)

THIS BILL STATES THAT A WORKER IS NOT CONSIDERED AN EMPLOYEE WHILE PARTICIPATING IN RECREATIONAL ACTIVITY <u>AND</u> ALSO NOT PERFORMING WORK DUTIES, IF USING A PASS, PERMIT OR OTHER EMPLOYER PROVIDED BENEFIT.

<u>OR</u> IS PERFORMING VOLUNTARY SERVICE AT A RECREATIONAL FACILITY AND IS GETTING NO COMPENSATION OTHER THAN MEALS, LODGING OR USE OF RECREATIONAL FACILITIES.

3-16-93
H.C. Package

THIS BILL IS SPECIFICALLY TO ADDRESS SKIING BY SKI HILL EMPLOYEES ON A PASS WHEN NOT WORKING. IN OTHER JURISDICTIONS, IT HAS BEEN DETERMINED THAT EVEN WHEN RECREATING THE EMPLOYEE IS COVERED IF THE EMPLOYER PROVIDED THE PASS AND PERHAPS EXPECTED THE EMPLOYEE TO BE ALERT TO DANGERS ON THE HILL SO AS TO WARN THE EMPLOYER OF THE PROBLEM. HOWEVER, THIS BILL AS WRITTEN COVERS ALL APPLICABLE SITUATIONS, NOT JUST SKI HILLS.

CH/sh

March 16, 1993

Exhibit 2, "Workers' Compensation Package Presentation", is 29 pages long. The original is stored at the Historical Society at 225 North Roberts Street, Helena, MT 59620-1201. The phone number is 444-2694.

EXHIBIT #4
DATE 3/16/93
HB HB Attachment

GENERAL WELL SERVICE, INC.

BOX 308
CUT BANK, MONTANA 59427
OFFICE PHONE (406) 873-5081
SHOP PHONE (406) 873-4862
FAX NUMBER: 1-406-873-5083

TELEFAX COVER SHEET

DATE: 3-17-93 FROM: General Well Service Leslie Ranck

TO: TOM NELSON, CHAIRMAN,

COMPANY: HOUSE LABOR + EMPLOYMENT RELATIONS COMMITTEE

ATTENTION: COMMITTEE MEMBERS FAX NO.: 1-444-4105

NUMBER OF PAGES INCLUDING COVER SHEET: 1

REFERENCE/COMMENTS:

We are in Support of the following:
SB-163, SB-164 SB-347, SB-394 (Harp)
H-B-361 (Hibbard)
H-B-620 (Ewer)
Thank You (Please vote in favor of)
Leslie Ranck

EXHIBIT 47
DATE 3/16/93
HB

Anderson's Masonry Supply

16 WOODLAND PARK DRIVE KALISPELL, MONTANA 59901
(406) 755-2497
FAX (406) 756-8706

Bill 431

FAX TRANSMITTAL FORM

DATE: 3-16-93

NUMBER OF PAGES - INCLUDING THIS ONE: 1

TO FAX #: 444-4105

COMPANY NAME: House Labor + Employment Relations Committee

ATTENTION: Tom Nelson - Gary Feland - Steve Benedict
Vicki Cocchiarella, Jerry Driscoll, Alvin Ellis,
Patrick Gervin, Sonny Hanson - Norm Mills
Bob Pavlovich, Bruce Simon, Carolyn Squires
Bill Tash, Ralph Tunby, Carley Tuss - Tom Whalen

~~FROM:~~

COMPANY NAME: Anderson's Masonry Supply

FAX #: (406) 756-8706

From: Tom Arvidson

COMMENTS:

Straighten out Work Comp
Vote for SB163 - SB164
SB347 - SB394 - HB361
+ HB622 These are
necessary parts of a good
Work Comp program.

IF ANY OF THE PAGES ARE NOT LEGIBLE, OR YOU DO NOT RECEIVE ALL OF THE PAGES, PLEASE CALL THE SENDER AT 1-406-755-2497

EXHIBIT 1/1 #6
DATE 3/16/93
HB Bus 431

EDSALL CONSTRUCTION COMPANY
GENERAL CONTRACTOR

P.O. BOX 1147 BOZEMAN, MONTANA 59771

PHONE (406) 587-0614
FAX (406) 585-1733

HOUSE LABOR COMMITTEE

AM MEMBERS,

I URGE YOUR SUPPORT FOR

3-16-93 SB 163
3-16-93 SB 164
3-16-93 SB 347
3-16-93 SB 394
3-16-93 HB 361
3-16-93 HB 662

THANK YOU.
EDSALL CONST.
Wayne Edsall Pres

BOX 308

CUT BANK, MONTANA 59427

OFFICE PHONE (406) 873-5081
SHOP PHONE (406) 873-4662

FAX NUMBER: 1-406-873-5083

TELEFAX COVER SHEET

DATE: 3-17-93

FROM: General Well Service
Leslie Ranch

TO: All Committee Members

COMPANY: Labor + Employment Relations Committee

ATTENTION: Tom Towe (Chairman FAX NO.: 1-444-4105

NUMBER OF PAGES INCLUDING COVER SHEET: _____

REFERENCE/COMMENTS:

HB-470 - I am against this bill - Please vote against.

HB-487 - I am in support of - Please vote for

Thank You
Leslie Ranch

EXHIBIT #7
DATE 3/16/93
HB Hon 431

SIDNEY MILLWORK CO.

Cambrian Lane
P.O. Box 1125
Sidney, Montana 59270
Phone (406) 482-2810
Fax (406) 482-2858

March 16, 1993

Tom Nelson, Chairman
House Labor & Employment Relation Committee

Dear Tom,

There are a number of bills that pertain to Workers Compensation that are before your committee.

I would like to encourage you to endorse the following bills:

SB 347 - (Harp)	The medical cost containment bill
SB 394 - (Harp)	Regulation of attorney fees.
HB 361 - (Hibbord)	Revising benefits & medical definitions

I also believe there is a bill to eliminate the requirement for a business to carry Workers Compensation Insurance. I believe this is fair. In the event of a loss, the individual business would be taken to court. His contribution to the loss and his ability to pay would be the determining factor.

Cordially,

Dolph M. Harris, President

Sidney Millwork Co.
Sidney, Montana

EXHIBIT 48
DATE 3/16/1993
HB

DIAMOND CONSTRUCTION, INC.
2905 NORTH MONTANA AVENUE
P O BOX 5987
HELENA, MT 59604-5987

PHONE: (406) 443-3373
FAX: (406) 442-2450

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Mr. Tom Nelson, Chairman (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Mr. Gary Feland, Vice Chairman (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DIAMOND CONSTRUCTION, INC.
2905 NORTH MONTANA AVENUE
P O BOX 5987
HELENA, MT 59604-5987

PHONE: (406) 443-3373
FAX: (406) 442-2450

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Mr. Steve Benedict, (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DATE: March 16, 1993

TO: Labor and Employment Relations Committe

ATTN: Ms. Vicki Cocchiarella (D)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DIAMOND CONSTRUCTION, INC.
2905 NORTH MONTANA AVENUE
P O BOX 5987
HELENA, MT 59604-5987

PHONE: (406) 443-3373
FAX: (406) 442-2450

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Mr. Jerry Driscoll, (D)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DATE: March 16, 1993

TO: Labor and Employment Relations Committe

ATTN: Mr. Alvin Ellis, Jr. (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DIAMOND CONSTRUCTION, INC.
2905 NORTH MONTANA AVENUE
P O BOX 5987
HELENA, MT 59604-5987

PHONE: (406) 443-3373
FAX: (406) 442-2450

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Mr. Patrick Galvin (D)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DATE: March 16, 1993

TO: Labor and Employment Relations Committe

ATTN: Mr. Sonny Hanson (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

Exhibit H
3-16-93

DIAMOND CONSTRUCTION, INC.
2905 NORTH MONTANA AVENUE
P O BOX 5987
HELENA, MT 59604-5987

PHONE: (406) 443-3373
*FAX: (406) 442-2450

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Mr. Norm Mills (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DATE: March 16, 1993

TO: Labor and Employment Relations Committe

ATTN: Mr. Bob Pavlovich (D)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DIAMOND CONSTRUCTION, INC.
2905 NORTH MONTANA AVENUE
P O BOX 5987
HELENA, MT 59604-5987

PHONE: (406) 443-3373
FAX: (406) 442-2450

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Mr. Bruce Simon (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DATE: March 16, 1993

TO: Labor and Employment Relations Committe

ATTN: Ms. Carolyn Squires (D)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DIAMOND CONSTRUCTION, INC.
2905 NORTH MONTANA AVENUE
P O BOX 5987
HELENA, MT 59604-5987

PHONE: (406) 443-3373
FAX: (406) 442-2450

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Mr. Bill Tash (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DATE: March 16, 1993

TO: Labor and Employment Relations Committe

ATTN: Mr. Roph Tunby (R)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

EXHIBIT #8
DATE 3-16-93
HB

DIAMOND CONSTRUCTION, INC.
2905 NORTH MONTANA AVENUE
P O BOX 5987
HELENA, MT 59604-5987

PHONE: (406) 443-3373
FAX: (406) 442-2450

DATE: March 16, 1993

TO: House Labor and Employment Relations Committe

ATTN: Ms. Carley Tuss (D)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

DATE: March 16, 1993

TO: Labor and Employment Relations Committe

ATTN: Mr. Tim Whalen (D)

FROM: Ardine (Dean) Bjerke

COMMENTS:

Please vote in favor for:

SB 163 (Harp)
SB 164 (Harp)
SB 347 (Harp)
SD 394 (Harp)
HB 361 (Hibbard)
HB 622 (Ewer)

3-16-93

EXHIBIT #10
DATE 3/16/93
HB

I Michael L Mizenko
MICHAEL S. MIZENKO

would like to be signed in as a proponent on the following bills

3-16-93 HB-453	Proponent	Cherrie will you Add This
HB-470	"	To HB 47
3-16-93 HB-622	"	List you HAJ &
3-16-93 HB-511	"	

I represent the Montana State Association of Plumbers & Pipefitters. I also the Mt. State Building & Const. Council

Thank You

I cannot be here for the hearings.

Homebuilders Assoc. of Billings
252-7533

S.W. Montana Home Builders Assoc.
585-8181

Great Falls Homebuilders Assoc.
452-HOME

Flathead Home Builders A
752-2522

Missoula Chapter of NAHI
273-0314

Helena Chapter of NAHB
449-7275

montana
BUILDING INDUSTRY
ASSOCIATION

Nancy Lien Griffin, Executive Director
Suite 4D Power Block Building • Helena, Montana 59601 • (406) 442-4479

EXHIBIT #9
DATE 3/16/93
HB

SB 163, 164, 347, 394
&
HB 361, 622

Recommend:
DO PASS

Mr. Chairman: Members of the Committee:

I am Harlee Thompson a delegate from the Montana Building Industry Association to the Coalition for Worker Compensation System Improvement. (CWCSI)

The Montana Building Industry Association (MBIA) and I would like to commend the Select Committee for the great job and long hard hours they have put into addressing the problems of our work comp system.

The Montana Building Industry Association wants to go on record as being in support of SB 163, 164, 347, 394 and HB 361,622. These bills are a very important part of the reforms that the Coalition for Work Comp System Improvement and the Montana Building Industry Association have been supporting in the effort to repair the mess the work comp system is in.

These bills deal with a large variety of concerns in the work comp system including issues from areas of safety, medical, fraud, and the legal profession.

We recommend a do pass on SB 163, 164, 347, 394 an HB 361, 622

EXHIBIT 42
DATE 3/16/93
HB 622

Amendments to House Bill No. 622
Second Reading Copy

For the Committee on Labor and Employment Relations
March 16, 1993

1.Title, line 21
Following: "Policyholders"
Insert: "ALLOWING GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE;"

2.Page 2, line 11
Insert: " STATEMENT OF INTENT
(This amendment requires that a statement of intent be attached to the bill because it requires the department rules to implement [Section 18 (4)]."

3.Page 30, line 25
Following: line 24
Insert: "

NEW SECTION. **Section 12. Definitions.** As used in [section 18], the following definitions apply:
(1) "Business entity" means a business enterprise owned by a single person or a corporation, organization, business trust, trust, partnership, joint venture, association, or other business entity.
(2) "Group" means two or more business entities that join together with the approval of the Department to purchase individual worker's compensation insurance policies covering each business entity that is a part of the group.

NEW SECTION. **Section 1. Group purchase of workers' compensation insurance.** (1) On receiving approval of the Department, two or more business entities may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.
(2) To be eligible to join a group, the department shall determine that a business entity is engaged in a business pursuit that is the same as or similar to the business pursuits of the other entities participating in the group.
(3) The department shall establish a certification program for groups organized under this section and shall issue to eligible business entities certificates of approval that authorize formation and maintenance of a group.
(4) The department by rule shall adopt forms, criteria, and procedures for the issuance of certificates of approval to groups under this section.
(5) A group certified under this section may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write worker's compensation insurance in this state. Under an individual

policy, the group is entitled to a premium or volume discount that would be applicable to a policy of the combined premium amount of the individual policies.

(6) A group shall apportion any discount or policy holder dividend received on worker's compensation insurance coverage among the members the group according to a formula adopted in the plan of operation for the group.

(7) A group shall adopt a plan of operation that must include the composition and selection of a governing board, the methods for administering the group, and guidelines for the workers' compensation insurance coverage obtained by the group including the payment of premiums, the distribution of discounts, and the method for providing risk management. A group shall file a copy of its plan of operation with the Department."

4. Page 49, line 9
Following: line 8
Insert: "(3) [Sections 12 and 13] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 12 and 13]."

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Labor & Employment Relations COMMITTEE BILL NO HB 622

DATE March 16, 1993 SPONSOR(S) D. Ewer

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
George Ward	Mt Self Insurers	✓ w/ amendment	
Gerri Whitmill	MT Chamber	✓	
Jay Stuce		✓	
Bill Errivello	Retail Assn of MT	✓	
Dan Cole	MMIA MSGIA MACO	✓	
Jerome B Connelly	MT Ch Amer P.T. Assoc	✓	
Jamie Doggett	MT Cattlewomen	✓	
Lorna Wright	Mt. Phys. Ther. Assn	✓	
HARLee Thompson	MBIA	✓	
Cars Ericsm	Carpenters Union - CWCSI	✓	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Labor & Employment Relations COMMITTEE BILL NO. HB 622

DATE March 16, 1993 SPONSOR(S) D. Ewer

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Charles R. Brooks	MT Retail Assoc	✓	
Don Judge	MT STATE AFL-CIO	X	
Dan Edwards	OCAW	X	
Russ Logan	Bldg Chamber	X	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

HOUSE OF REPRESENTATIVES
VISITOR REGISTER

Labor & Employment Relations COMMITTEE BILL NO. HB 622

DATE March 16, 1993 SPONSOR(S) D. Ewer

PLEASE PRINT PLEASE PRINT PLEASE PRINT

NAME AND ADDRESS	REPRESENTING	SUPPORT	OPPOSE
Jacqueline Lenmark	Am. Ins. Assoc.	X	
Michael S. Mizenko	Mt. State Assoc. Plumbers & Pipefitters Mt. State Building Const. Council	X	
WAYNE EDSALL	EDSALL Construction	X	
Mike Micone	MMCA	Amend X	

PLEASE LEAVE PREPARED TESTIMONY WITH SECRETARY. WITNESS STATEMENT FORMS ARE AVAILABLE IF YOU CARE TO SUBMIT WRITTEN TESTIMONY.

MINUTES

MONTANA HOUSE OF REPRESENTATIVES
53rd LEGISLATURE - REGULAR SESSION

COMMITTEE ON LABOR & EMPLOYMENT RELATIONS

Call to Order: By Chairman Tom Nelson, on March 18, 1993, at 3:00 p.m.

ROLL CALL

Members Present:

Rep. Tom Nelson, Chair (R)
Rep. Gary Feland, Vice Chair (R)
Rep. Steve Benedict (R)
Rep. Vicki Cocchiarella (D)
Rep. Jerry Driscoll (D)
Rep. Alvin Ellis (R)
Rep. Pat Galvin (D)
Rep. Sonny Hanson (R)
Rep. Norm Mills (R)
Rep. Bob Pavlovich (D)
Rep. Carolyn Squires (D)
Rep. Bill Tash (R)
Rep. Rolph Tunby (R)
Rep. Carley Tuss (D)
Rep. Tim Whalen (D)

Members Excused: Rep. Simon

Members Absent: None

Staff Present: Susan Fox, Legislative Council
Cherri Schmaus, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing:	None
Executive Action:	SB 163, HB 453, SB 164, HB 587, HB 622, HB 361, SB 347, HB 628, SB 394, HB 504, HB 13, HB 511

EXECUTIVE ACTION ON SB 163

Motion: **REP. DRISCOLL MOVED SB 163 DO BE CONCURRED IN.**

Discussion: None

EXECUTIVE ACTION ON HB 622

Motion: **REP. FELAND MOVED HB 622 DO PASS.** He proposed two sets of amendments.

Discussion: **REP. HIBBARD** explained the amendments and stated that they are a technical clean-up. These amendments will disallow a lump sum payment.

REP. DRISCOLL stated that workers used to have a lifetime of benefits and now they only get 60 months.

The question was called on the #1 Feland amendment. The motion **CARRIED** unanimously.

The question was called on the #2 Feland amendment. The motion **FAILED** with a vote of 6 to 10.

REP. HANSON proposed an amendment to strike section 10 entirely. **REP. HIBBARD** explained the amendment.

REP. DRISCOLL stated that all other insurers must meet the requirements.

Don Allen, Coalition, agreed to offer this as another option.

REP. HANSON withdrew the amendment.

REP. HANSON proposed another amendment that allows group purchase of workers compensation insurance. **REP. HIBBARD** explained that this amendment entitles two or more businesses to qualify for a group savings. This amendment was brought forth by the carriers. **REP. HANSON** stated that he currently buys his insurance from Washington and he feels that everyone should be able to do this.

REP. BENEDICT stated that he supports the amendment.

Susan Fox, Legislative Council, stated that a statement of intent has not yet been submitted.

REP. SQUIRES asked **REP. DRISCOLL** if people go inform other groups, will they be independent of the State Fund?

REP. DRISCOLL stated that they would be if they get big enough for a volume discount.

REP. BENEDICT stated that those who feel trapped can go outside the State Fund.

REP. HANSON asked **REP. DRISCOLL** if they get a rebate is the estimated rate for the group. Those not causing problems get a dividend.

REP. COCCHIARELLA stated that the committee needs a statement of intent or else they are voting on half a concept.

REP. BENEDICT agreed with **REP. COCCHIARELLA.**

The question was called on the Hanson amendment. The motion **CARRIED** 10 to 5.

REP. DRISCOLL proposed an amendment. He told the committee if more than one insurance company is involved, the claim is apportioned between them after maximum healing.

REP. BENEDICT told **REP. DRISCOLL** this applies to injuries that occur outside. He asked if they could amend it to read "preexisting injuries". This would allow it to be apportioned between workers compensation carriers and medical insurers.

REP. DRISCOLL replied that this does not stop 100 percent medical, it just clarifies who pays.

The question was called on the Driscoll amendment.. The motion **CARRIED** unanimously.

REP. COCCHIARELLA explained her proposed amendment **(EXHIBIT #2).**

REP. BENEDICT stated that he supports **REP. COCCHIARELLA.**

The question was called for on the Cocchiarella amendments. The motion **CARRIED** unanimously.

REP. WHALEN proposed an amendment to strike the new subsection 2, line 10 through 17 entirely. This would provide penalties for lawyers who don't advertise correctly in yellow pages, they can be filed against or charged with fraud.

REP. BENEDICT stated that he is opposed to the amendment.

The question was called on the Whalen amendment. The motion **CARRIED** 9 to 7.

REP. WHALEN proposed another amendment on page 31, section 12, lines 11 through 15. He wants to clear up the wording because it doesn't apply to good faith.

REP. BENEDICT told **REP. WHALEN** that this could open it up to subjectivity and determining what is good faith.

REP. WHALEN stated that he doesn't feel this would happen.

Don Allen, without objection of the committee, stated that this amendment will water down the bill.

REP. WHALEN stated that the word "knowing" doesn't relate to the

end result.

REP. ELLIS stated that he is against the amendment because it refers to claims and the word "knowingly" is subject to abuse.

REP. BENEDICT agreed with **REP. ELLIS.**

The question was called on the #2 Whalen amendment. The motion **FAILED** 7 to 9.

Motion/Vote: REP. DRISCOLL MOVED HB 622 DO PASS AS AMENDED. The question was called. A voice vote was taken. The motion **CARRIED** 15 to 1 with **REP. WHALEN** voting no.

EXECUTIVE ACTION ON HB 361

Motion: REP. BENEDICT MOVED HB 361 DO PASS.

Discussion: REP. COCCHIARELLA moved her proposed amendments. The question was called for on the Cocchiarella amendments **(EXHIBIT #3).** The motion **CARRIED** unanimously.

Motion/Vote: REP. BENEDICT MOVED HB 361 DO PASS AS AMENDED. The question was called for. A voice vote was taken. The motion **CARRIED** 11 to 5 with **REP'S COCCHIARELLA, TUSS, PAVLOVICH, SQUIRES AND DRISCOLL** voting no.

EXECUTIVE ACTION ON SB 347

Motion: REP. BENEDICT MOVED SB 347 DO BE CONCURRED IN.

Discussion: REP. BENEDICT moved his proposed amendments **(EXHIBIT #4). REP. WHALEN** asked how this amendment fits in?

REP. BENEDICT replied that it encourages service providers to utilize physical therapy.

REP. ELLIS stated that he supports the amendment.

The question was called on the amendment. The motion **CARRIED.**

REP. WHALEN proposed an amendment to add the word "reasonably" to page 25, section 10, line 13.

REP. BENEDICT stated that he resists the amendment.

The question was called on the Whalen amendments. The motion **FAILED** 7 to 9.

REP. DRISCOLL stated that this bill is trying to get medical cost down and passage of SB 347 is a good idea.

HOUSE OF REPRESENTATIVES

LABOR COMMITTEE

ROLL CALL DATE 3/10/93

NAME	PRESENT	ABSENT	EXCUSED
REP. TOM NELSON, CHAIRMAN	✓		
REP. GARY FELAND, VICE CHAIRMAN	✓		
REP. STEVE BENEDICT	✓		
REP. VICKI COCCHIARELLA	✓		
REP. JERRY DRISCOLL	✓		
REP. ALVIN ELLIS	✓		
REP. PAT GALVIN	✓		
REP. SONNY HANSON	✓		
REP. NORM MILLS	✓		
REP. BOB PAVLOVICH	✓		
REP. BRUCE SIMON			✓
REP. CAROLYN SQUIRES	✓		
REP. BILL TASH	✓		
REP. ROLPH TUNBY	✓		
REP. CARLEY TUSS	✓		
REP. TIM WHALEN	✓		

3/18/19

Gary Farland has
my proxy for all
votes that I miss in
House Labor today

Adam Bigl

3-18-93

Please vote one with Rep Nelson on all bills and amendments this day

Rep. Bruce Simon

EXHIBIT #1
DATE 3/10/93
HB UC package

Amendments to House Bill No. 453
First Reading Copy

Requested by Rep. Benedict
For the House Select Committee on Workers' Compensation

Prepared by Sheri S. Heffelfinger
March 12, 1993

1. Page 1, line 22.
Following: "(2)"
Insert: "(a)"

2. Page 2.
Following: line 3
Insert: "(b) As used in subsection (2) (a), "person" includes but is not limited to an employee, employer, or medical service provider."

EXHIBIT #1
DATE 3/18/93
HB 622 passage

Amendments to House Bill No. 622
Second Reading Copy

Requested by Rep. Cocchiarella
For the Committee on Labor and Employment Relations

Prepared by Susan B. Fox
March 18, 1993

1. Title, page 2, line 4.
Following: "PLAN;"
Insert: "REQUIRING THE INSURER TO NOTIFY CLAIMANTS OF BENEFITS AND ENTITLEMENTS USING INFORMATION PROVIDED BY THE DEPARTMENT;"

2. Title, page 2, line 7.
Following: "39-71-605,"
Insert: "39-71-606,"

3. Page 20, line 25 through page 21, line 5.
Strike: subsection (7) in its entirety

4. Page 48, line 17.
Following: line 16
Insert: "**Section 23.** Section 39-71-606, MCA, is amended to read:

"39-71-606. Insurer to accept or deny claim within thirty days of receipt -- notice of denial -- notice to employer. (1) Every insurer under any plan for the payment of workers' compensation benefits shall, within 30 days of receipt of a claim for compensation, either accept or deny the claim, and if denied shall inform the claimant and the department in writing of such denial.

(2) The department shall make available to insurers for distribution to claimants sufficient copies of a document describing current benefits and entitlements available under Title 39, chapter 71. Upon receipt of a claim, each insurer shall promptly notify the claimant in writing of potential benefits and entitlements available by providing the claimant a copy of the document prepared by the department.

(3) Upon the request of an employer it insures, an insurer shall notify the employer of all compensation benefits that are ongoing and are being charged against that employer's account.""
Renumber: subsequent sections

EXHIBIT #3
DATE 3/10/93
HB WC package

Amendments to House Bill No. 361
Second Reading Copy

Requested by Rep. Cocchiarella
For the Committee on Labor and Employment Relations

Prepared by Susan B. Fox
March 18, 1993

1. Title, line 10.
Following: "CLAIMS;"
Insert: "REQUIRING THE INSURER TO NOTIFY CLAIMANTS OF BENEFITS AND ENTITLEMENTS USING INFORMATION PROVIDED BY THE DEPARTMENT;"

2. Page 37, line 14.
Following: "receipt"
Insert: "-- notice of benefits and entitlements to claimants"

3. Page 37, line 21.
Following: line 20
Insert: "(2) The department shall make available to insurers for distribution to claimants sufficient copies of a document describing current benefits and entitlements available under Title 39, chapter 71. Upon receipt of a claim, each insurer shall promptly notify the claimant in writing of potential benefits and entitlements available by providing the claimant a copy of the document prepared by the department."
Renumber: subsequent subsections

EXHIBIT 44
DATE 3/16/93
HB WC package

Amendments to Senate Bill No. 347
Third Reading Copy

Requested by Sen. Harp
For the Committee on Labor and Employment Relations

Prepared by Susan B. Fox
March 18, 1993

1. Page 22, line 3.
Following: "care."
Insert: "When a health care provider, a group of medical service providers, or an entity with a managed care organization is establishing a managed care organization and independent physical therapy practices exist in the community, the managed care organization is encouraged to utilize independent physical therapists as part of the managed care organization if the independent physical therapists agree to abide by all the applicable requirements for a managed care organization set forth in this section, in rules established by the department, and in the provisions of a managed care plan for which certification is being sought."

EXHIBIT #5
DATE 3/18/93
HB WC Package

Amendments to House Bill No. 504
Second Reading Copy

Requested by Representative Benedict
For the Committee on Labor

Prepared by Greg Petesch
March 18, 1993

1. Page 11, line 11.
Following: "(III)"
Insert: "(A)"

2. Page 11, line 17.
Following: line 16
Insert: "(B) If the debt service account has sufficient funds to pay outstanding bonds or if no bonds are outstanding, the payroll tax may not be imposed after the end of fiscal year 2003."

EXHIBIT #6
DATE 3/18/93
HB WC bills

Amendments to House Bill No. 13
Second Reading Copy

Requested by Rep. Cocchiarella
For the Committee on Labor and Employment Relations

Prepared by Susan B. Fox
March 18, 1993

1. Title, line 14.
Following: "APPROPRIATION;"
Insert: "REQUIRING THE INSURER TO NOTIFY CLAIMANTS OF BENEFITS AND ENTITLEMENTS USING INFORMATION PROVIDED BY THE DEPARTMENT;"

2. Title, line 15.
Following: "18-8-103,"
Insert: "39-71-606,"

3. Page 16, line 15.
Following: line 14
Insert: "**Section 12.** Section 39-71-606, MCA, is amended to read:

"39-71-606. Insurer to accept or deny claim within thirty days of receipt -- notice of denial -- notice to employer. (1) Every insurer under any plan for the payment of workers' compensation benefits shall, within 30 days of receipt of a claim for compensation, either accept or deny the claim, and if denied shall inform the claimant and the department in writing of such denial.

(2) The department shall make available to insurers for distribution to claimants sufficient copies of a document describing current benefits and entitlements available under Title 39, chapter 71. Upon receipt of a claim, each insurer shall promptly notify the claimant in writing of potential benefits and entitlements available by providing the claimant a copy of the document prepared by the department.

(3) Upon the request of an employer it insures, an insurer shall notify the employer of all compensation benefits that are ongoing and are being charged against that employer's account.""

Renumber: subsequent sections

4. Page 17, line 12.
Strike: "14"
Insert: "15"

Amendments to House Bill No. 622
Second Reading Copy

Requested by Rep. Hibbard
For the Committee on Labor and Employment Relations

Prepared by Susan B. Fox
March 16, 1993

1. Title, lines 15 and 16.
Strike: line 15 in its entirety through "DISPUTES;" on line 16

2. Page 24, line 13 through page 26, line 8.
Strike: section 8 in its entirety
Renumber: subsequent sections

3. Page 48, line 22.
Strike: "[SECTIONS 8 AND 9] ARE"
Insert: "[Section 8] is"

4. Page 48, line 25 through page 49, line 1.
Strike: "[SECTIONS 8 AND 9]"
Insert: "[section 8]"

5. Page 49, line 2.
Page 49, line 5.
Strike: "11"
Insert: "10"

6. Page 49, line 6.
Page 49, line 8.
Strike: "19 AND 20"
Insert: "18 and 19"

Amendments to House Bill No. 622
Second Reading Copy

Requested by Rep. Hibbard
For the Committee on Labor and Employment Relations

Prepared by Susan B. Fox
March 16, 1993

1. Title, page 2, line 7.
Strike: "39-71-741,"

2. Page 15, line 3 through page 18, line 17.
Strike: section 5 in its entirety
Renumber: subsequent sections

3. Page 48, line 22.
Strike: "8 AND 9"
Insert: "7 and 8"

4. Page 48, line 25 through page 49, line 1
Strike: "8 AND 9"
Insert: "7 and 8"

5. Page 49, lines 2 and 5.
Strike: "11"
Insert: "10"

6. Page 49, lines 6 and 8.
Strike: "19 AND 20"
Insert: "18 and 19"

Amendments to House Bill No. 622
Second Reading Copy

Requested by Rep. Hibbard
For the Committee on Labor and Employment Relations

Prepared by Susan B. Fox
March 16, 1993

1. Title, lines 19 and 20.
Following: "~~HIRING;~~" on line 19
Strike: the remainder of line 19 through "SELF-INSURE;" on line 20

2. Title, page 2, line 8.
Strike: "39-71-2101,"

3. Page 27, line 24 through page 28, line 19.
Strike: section 10 in its entirety
Renumber: subsequent sections

4. Page 49, line 2.
Page 49, line 5
Strike: "11"
Insert: "10"

5. Page 49, line 6.
Page 49, line 8.
Strike: "19 AND 20"
Insert: "18 and 19"

Amendments to House Bill No. 622
Second Reading Copy

Requested by Rep. Driscoll
For the Committee on Labor and Employment Relations

Prepared by Susan B. Fox
March 18, 1993

1. Title, page 1, line 12.
Following: "INFIRMITY;"
Insert: "ALLOWING APPORTIONMENT OF COMPENSATION FOR PREEXISTING CONDITIONS BETWEEN INSURERS;"

2. Title, page 2, line 7.
Following: "39-71-316,"
Insert: "39-71-407,"

3. Title, page 2, line 8.
Strike: "AND"
Following: "39-72-303,"
Insert: "39-72-706, and 39-72-707,"

4. Page 48, line 17.
Following: line 16
Insert: "**Section 23.** Section 39-71-407, MCA, is amended to read:

"**39-71-407. Liability of insurers -- limitations -- apportionment.** (1) Every insurer is liable for the payment of compensation, in the manner and to the extent ~~hereinafter~~ provided in this section, to an employee of an employer it insures who receives an injury arising out of and in the course of ~~his~~ employment or, in the case of ~~his~~ death from ~~such~~ the injury, to ~~his~~ the employee's beneficiaries, if any.

(2) (a) An insurer is liable for an injury as defined in 39-71-119 if the claimant establishes it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that ~~such~~ the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(3) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(a) (i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement; and

(ii) the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(b) the travel is required by the employer as part of the employee's job duties.

(4) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the sole and exclusive cause of the injury or death. However, if the employer had

knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

(5) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(6) If an injury, as defined in 39-71-119, occurs that involves an aggravation of a preexisting condition, the permanent total, permanent partial, and medical benefits payable under this chapter after a worker reaches maximum healing must be apportioned between the insurer or insurers who are liable for coverage for the preexisting condition and the insurers who are liable for coverage for the aggravation injury. The insurer for the injury is responsible only for the portion attributable to the aggravation injury.

(7) If a workers' compensation insurer had a compensable claim for the preexisting condition, the insurer remains liable for the portion attributable to that insurer for permanent total, permanent partial, and medical benefits."

Section 24. Section 39-72-706, MCA, is amended to read:

"**39-72-706. Aggravation -- apportionment.** (1) If an occupational disease is aggravated by any other disease or infirmity not itself compensable or if disability or death from any other cause not itself compensable is aggravated, prolonged, accelerated, or in any way contributed to by an occupational disease, the compensation payable under this chapter must be ~~reduced and limited to such proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as such occupational disease as a causative factor bears to all the causes of such disability or death~~ apportioned between the liability attributable to the preexisting condition and the liability attributable to the occupational disease after the injured worker reaches maximum healing.

(2) If a workers' compensation insurer had a compensable claim for the preexisting condition, the insurer remains liable for the portion attributable to that insurer for benefits paid.

~~(2)~~(3) If compensation is ~~reduced a proportionate amount~~ apportioned as provided in subsection (1) and the worker receives disability social security benefits, the offset entitlement granted to the insurer must be ~~reduced~~ apportioned in the same proportionate amount as the compensation as long as the worker continues to receive disability social security benefits."

Section 25. Section 39-72-707, MCA, is amended to read:

"**39-72-707. Silicosis with complications.** In cases of disability or death from silicosis complicated with tuberculosis of the lungs, compensation ~~shall~~ must be payable as for disability or death from an uncomplicated silicosis. In case of disability or death from silicosis when complicated with any disease not compensable under this chapter and other than pulmonary tuberculosis, compensation ~~shall be reduced~~ must be apportioned as provided in 39-72-706.""

Renumber: subsequent sections

HOUSE STANDING COMMITTEE REPORT

March 19, 1993

Mr. Speaker: We, the committee on Labor report that House Bill 622 (second reading copy -- yellow) do pass as amended.

Signed: Tom Nelson
Tom Nelson, Chair

And, that such amendments read:

1. Title, page 1, line 12.
Following: "INFIRMITY;"
Insert: "ALLOWING APPORTIONMENT OF COMPENSATION FOR PREEXISTING CONDITIONS BETWEEN INSURERS;"

2. Title, lines 15 and 16.
Strike: line 15 in its entirety through "DISPUTES;" on line 16

3. Title, page 2, line 4.
Following: "PLAN;"
Insert: "ALLOWING GROUP PURCHASE OF WORKERS' COMPENSATION INSURANCE; REQUIRING THE INSURER TO NOTIFY CLAIMANTS OF BENEFITS AND ENTITLEMENT USING INFORMATION PROVIDED BY THE DEPARTMENT;"

4. Title, page 2, line 7.
Following: "39-71-316,"
Insert: "39-71-407,"

5. Title, page 2, line 7.
Following: "39-71-605,"
Insert: "39-71-606,"

6. Title, page 2, line 8.
Strike: "AND"
Following: "39-72-303,"
Insert: "39-72-706, and 39-72-707,"

7. Page 2, line 11.
Insert: "
STATEMENT OF INTENT

A statement of intent is required for this bill because [section 23] requires the department by rule to adopt forms, criteria, and procedures for the issuance of certificates of approval for groups eligible to purchase group insurance. The rules adopted by the department must:

Committee Vote:
Yes 15, No 1.

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(1) be consistent with the provisions of Title 39, chapter 71, and [this act]; and

(2) address who may be in a group, how a member may be removed from the group, the criteria for certification, the apportionment of dividends or discounts, the requirements for a plan of operation, and any reporting requirements that may be necessary."

8. Page 20, line 25 through page 21, line 5.
Strike: subsection (7) in its entirety

9. Page 24, line 13 through page 26, line 8.
Strike: section 8 in its entirety
Renumber: subsequent sections

10. Page 44, line 5.
Strike: "(3)"
Insert: "(2)"

11. Page 45, lines 10 through 17.
Strike: subsection 2 in its entirety
Renumber: subsequent subsection

12. Page 48, line 17.
Following: line 16
Insert: "NEW SECTION. Section 22. Definitions. As used in [section 23], the following definitions apply:

(1) "Business entity" means a business enterprise owned by a single person, corporation, organization, business trust, trust, partnership, joint venture, association, or other business entity.

(2) "Group" means two or more business entities that join together with the approval of the department to purchase individual workers' compensation insurance policies covering each business entity that is part of a group.

NEW SECTION. Section 23. Group purchase of workers' compensation insurance. (1) On receiving approval of the department, two or more business entities may join together to form a group to purchase individual workers' compensation insurance policies covering each member of the group.

(2) To be eligible to join a group, the department shall determine that a business entity is engaged in a business pursuit that is the same as or similar to the business pursuits of the other entities participating in the group.

(3) The department shall establish a certification program for groups organized under this section and shall issue to eligible business entities certificates of approval that authorize formation and maintenance of a group.

(4) The department by rule shall adopt forms, criteria, and procedures for the issuance of certificates of approval to groups under this section.

(5) A group certified under this section may purchase individual workers' compensation insurance policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state. Under an individual policy, the group is entitled to a premium or volume discount that would be applicable to a policy of the combined premium amount of the individual policies.

(6) A group shall apportion any discount or policyholder dividend received on workers' compensation insurance coverage among the members of the group according to a formula adopted in the plan of operation for the group.

(7) A group shall adopt a plan of operation that must include the composition and selection of a governing board, the methods for administering the group, and guidelines for the workers' compensation insurance coverage obtained by the group, including the payment of premiums, the distribution of discounts, and the method for providing risk management. A group shall file a copy of its plan of operation with the department."

Section 24. Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations -- apportionment. (1) Every insurer is liable for the payment of compensation, in the manner and to the extent ~~hereinafter~~ provided in this section, to an employee of an employer it insures who receives an injury arising out of and in the course of ~~his~~ employment or, in the case of ~~his~~ death from ~~such~~ the injury, to ~~his~~ the employee's beneficiaries, if any.

(2) (a) An insurer is liable for an injury as defined in 39-71-119 if the claimant establishes it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that ~~such~~ the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(3) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(a) (i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement; and

(ii) the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(b) the travel is required by the employer as part of the employee's job duties.

(4) An employee is not eligible for benefits otherwise

payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the sole and exclusive cause of the injury or death. However, if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

(5) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(6) If an injury, as defined in 39-71-119, occurs that involves an aggravation of a preexisting condition, the permanent total, permanent partial, and medical benefits payable under this chapter after a worker reaches maximum healing must be apportioned between the insurer or insurers who are liable for coverage for the preexisting condition and the insurers who are liable for coverage for the aggravation injury. The insurer for the injury is responsible only for the portion attributable to the aggravation injury.

(7) If a workers' compensation insurer had a compensable claim for the preexisting condition, the insurer remains liable for the portion attributable to that insurer for permanent total, permanent partial, and medical benefits."

Section 25. Section 39-72-706, MCA, is amended to read:

"39-72-706. Aggravation -- apportionment. (1) If an occupational disease is aggravated by any other disease or infirmity not itself compensable or if disability or death from any other cause not itself compensable is aggravated, prolonged, accelerated, or in any way contributed to by an occupational disease, the compensation payable under this chapter must be ~~reduced and limited to such proportion only of the compensation that would be payable if the occupational disease were the sole cause of the disability or death as such occupational disease as a causative factor bears to all the causes of such disability or death~~ apportioned between the preexisting condition and the liability attributable to the occupational disease after the worker reaches maximum healing.

(2) If a workers' compensation insurer had a compensable claim for the preexisting condition, the insurer remains liable for the portion attributable to that insurer for benefits paid.

~~(2)~~ (3) If compensation is ~~reduced a proportionate amount~~ apportioned as provided in subsection (1) and the worker receives disability social security benefits, the offset entitlement granted to the insurer must be ~~reduced~~ apportioned in the same proportionate amount as the compensation as long as the worker continues to receive disability social security benefits."

Section 26. Section 39-72-707, MCA, is amended to read:

"39-72-707. Silicosis with complications. In cases of disability or death from silicosis complicated with tuberculosis of the lungs, compensation ~~shall~~ must be payable as for disability or death from an uncomplicated silicosis. In case of disability or death from silicosis when complicated with any disease not compensable under this chapter and other than pulmonary tuberculosis, compensation ~~shall be reduced~~ must be apportioned as provided in 39-72-706."

Section 27. Section 39-71-606, MCA, is amended to read:
"39-71-606. Insurer to accept or deny claim within thirty days of receipt -- notice of denial -- notice to employer. (1) Every insurer under any plan for the payment of workers' compensation benefits shall, within 30 days of receipt of a claim for compensation, either accept or deny the claim, and if denied shall inform the claimant and the department in writing of such denial.

(2) The department shall make available to insurers for distribution to claimants sufficient copies of a document describing current benefits and entitlement available under Title 39, chapter 71. Upon receipt of a claim, each insurer shall promptly notify the claimant in writing of potential benefits and entitlement available by providing the claimant a copy of the document prepared by the department.

(3) Upon the request of an employer it insures, an insurer shall notify the employer of all compensation benefits that are ongoing and are being charged against that employer's account.""
Renumber: subsequent sections

13. Page 48, line 22.
Strike: "[SECTIONS 8 AND 9] ARE"
Insert: "[Section 8] is"

14. Page 48, line 25 through page 49, line 1.
Strike: "[SECTIONS 8 AND 9]"
Insert: "[section 8]"

15. Page 49, line 2.
Page 49, line 5.
Strike: "11"
Insert: "10"

16. Page 49, line 6.
Page 49, line 8.
Strike: "19 AND 20"
Insert: "18 and 19"

17. Page 49, line 9.
Following: line 8

Insert: "(4) [Sections 22 and 23] are intended to be codified as an integral part of Title 39, chapter 71, and the provisions of Title 39, chapter 71, apply to [sections 22 and 23]."

MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By Senator Tom Towe, on April 2, 1993, at 3:03 PM.

ROLL CALL

Members Present:

Sen. Tom Towe, Chair (D)
Sen. Gary Forrester, Vice Chair (D)
Sen. Gary Aklestad (R)
Sen. Sue Bartlett (D)
Sen. Jim Burnett (R)
Sen. John Harp (R)
Sen. John Hertel (R)
Sen. Bob Hockett (D)
Sen. Tom Keating (R)
Sen. J.D. Lynch (D)
Sen. Bill Wilson (D)

Members Excused: None.

Members Absent: Sen. Harry Fritz (D)

Staff Present: Susan Fox, Legislative Council
Kelsey Chapman, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:

Hearing: HB 622, HB 361
Executive Action: None.

HEARING ON HB 622

Opening Statement by Sponsor:

Representative David Ewer, House District 45, told the Committee HB 622 was a conglomeration of workers' compensation issues. He said it was a bill brought together by a coalition of businesses and workers. He said HB 622 established a new category of injured worker disability, being "temporary partial", which would allow a worker to receive benefits from workers' compensation and in addition work with the employer in a lesser job, and receive wages to some extent, as well as benefits. He said this provision would provide incentive to workers to go back to work.

Representative Ewer said on page 15, an injured worker that fails to keep medical appointments would forfeit claims benefits. He said this was a good disincentive for a worker to fail to keep medical appointments. He said HB 622 also allowed for lump sum payments of medical benefits. A new section 10 on page 29 provided for there to be deductibles for insurance companies. He explained this would not hurt the workers, but rather allow the employer to purchase a policy and have a large deductible. If there was a claim, the employer could pay back the deductible over a period of time. The employer would have to be credit-worthy to get this insurance. Section 11 attempted to augment SB 164, Senator Harp's fraud bill, and provide that people who knowingly file claims that are fraudulent are themselves guilty of fraud. Representative Ewer said section 8 dealt with medical providers and what kinds of actions by these providers were subject to penalties. He said section 21 provided the State Fund must adopt a business plan that includes specific goals. He said HB 13 tried to give the State Fund the flexibility it needed, but at the same time, HB 622 made some analogous requirements for the Fund to be held responsible for actions, and to act like a corporation. Section 23 would provide for group discounts, but would not obligate the Fund to accept a group. He said there was a section that dealt with employers who employed workers covered by collective bargaining. This section would enable the employers to use the pension assets of the employees to enable the employer to self insure if the employee wanted to trust the employer.

Proponents' Testimony:

Jim Puttman, Coalition for Workers' Compensation System Improvement, offered an amendment to page 27, line 12. He recommended "weekly compensation benefits" be stricken, and "an insurers' liability" be inserted. On page 27, line 18, he recommended that "state's average weekly wage at the time of injury" be stricken, and "a workers' temporary total disability rate" be inserted. He explained as HB 622 presently read, the injured worker that returns to work could earn more than the temporary total disability rate. He said the worker should not retrieve more than the benefits that would have been earned if the worker was totally disabled. He stated the amendment would limit the insurers' liability to the temporary total disability, but still allow for the partially disabled worker who returned to work in a lesser capacity to earn more than the total disability benefits would be. He recommended page 25, section 8, stricken in the House, be reinstated. He said the apportionment issue should not be open for dispute between the worker and the employer or the insurer, but rather be independently assessed. Section 8 would provide for a panel to assess the apportionment, but would also allow that should an insurer or a worker agree with predetermine apportionment, the panel would not have to be used. He said the panel currently existed under the occupational disease act, and would not require any change in the evaluation process that was currently in effect. It would provide for an

independent assessment of apportionment. Mr. Puttman said apportionment was a new concept for Montana, and would require change. He stated apportionment was based on apportioning liability to those responsible for the injury, rather than having an employer take the brunt for a preexisting work-related injury. He explained there were additional federal laws to take into consideration when dealing with workers' compensation. The Americans with Disabilities Act (ADA) requires that employers hire people with known disabilities, but gives those employers no opportunity to apportion liability for conditions unrelated to that employment. Under the apportionment in HB 622 a medical panel would assess who's liability belongs to whom. The employer and insurer would then be assigned that liability attributable to the aggravation. All benefits up to the time the employer reaches maximum healing would be paid in full. Once that individual has reached maximum healing, there would be a limitation on the part of the employer, providing the preexisting condition was aggravated, and providing there was less than 100% on the part of the employer. If here is an insurer on record for a previously unsettled workers' compensation claim, the employer would have the right to go back to the insurer and request further benefits. Mr. Puttman said the medical panel would make the decision as to the liability, and thus limit debate between insurance companies that would not want to accept liability. He stated apportionment worked in other insurance industries in Montana and other states with workers' compensation insurance. He said apportionment was fair for all parties involved.

Jim Senrud, Chairman of the Coalition for Workers' Compensation System Improvement, told the Committee the fairness and cost issues were the arguments for apportionment. He said there were insurance companies and employers who knew how to use employees until they are hurt badly, and then get rid of them. If those employees were employed with other employers, those employers would pay for the whole injury of those employees caused by the previous employers.

Harley Thompson, Montana Building Association, spoke from written testimony (Exhibit #1).

George Wood, Montana Self Insurers' Association (MSIA), handed out reference sheets to the Committee (Exhibit #2 and 2a). He said MSIA strongly supported temporary partial, but did not think the Coalition's amendment went far enough. He said in the Workers' Compensation Act the sections that deal with benefits provide an injured worker will receive 66⅔ percent of the loss of wage as a benefits. He stated that the Coalition's amendment said that any benefits that the employee receives after returning to work is not subject to the 66⅔ percent benefits. He said he was confused as to the exact benefits an injured worker would receive under the apportionment section. He asked how apportionment would work if the preexisting condition was congenital, developmental, caused by illness, or caused by something non industrial. He asked if the insurer would have to

interplead to every previous employer to find in which workplace the preexisting condition originated. Mr. Wood said that section 8 had a method for dealing with apportioning, but did not specify a mechanism for getting information. He said HB 622 should pass, if the proposed amendments to the temporary partial disability were adopted, and the apportionment section was stricken.

Gary Willis, Montana Power Company, said that the 66⅔ percent temporary partial benefits should be amended into HB 622, and that MPC supported the Bill.

Reily Johnson, National Federation of Independent Businesses (NFIB), told the Committee to amend the temporary partial section. He said NFIB supported the coalition in the apportionment issue. He stated NFIB was concerned with the ADA, and was wondering how to address these laws. He asked the Committee to look at apportionment and try to address this issue.

Jan Van Riper, an attorney in Helena, said she did not support lump summing of medical benefits. She said many injured workers, when it came time to settle claims, needed money, but it was in the workers best interest to keep the medical benefits open, rather than lump summing. She said apportionment was a very confusing section, and may cause litigation. She said the section assumed that there was a prior workers' compensation insurer in the picture, but that was not always true. She said she understood the fairness issue, but not all injuries were equal; and the ADA problem was dealt with in Montana through the subsequent injury fund.

Oliver Goe, Montana Municipal Insurance Authority (MMIA), Montana Association of Counties (MACO), and Montana School Groups Insurance Authority (MSGIA), said these associations were in general agreement with HB 622. He said there were concerns about four provisions that either conflicted with HB 361 or caused problems in general claims management. He said lump summing benefits was not a good idea for the reasons Ms. Van Riper noted, as well as for the reason that the insurer could be hurt if there was a reopening of the claim after a lump sum settlement. He said temporary partial disability was a good mechanism for getting injured workers back to work. He said the difference should be 66⅔ percent. He said it could be amended in page 27, line 13. He also expressed concern with page 47, line 11, the augmentation of temporary total disability benefits with sick leave. He said this section is a disincentive to go back to work and also treats employees that have a collective bargaining agreement differently than those that do not. He said if the person is getting workers' compensation benefits plus the remainder of a salary, there would be no incentive to go back to work. He said the apportionment portion of HB 622 could open up the workers' compensation system to litigation.

Nancy Butler, General Council, State Fund, said the State Fund had concerns about the lump summing of medical benefits on page

18. She said HB 622 allowed for lump summing of medical benefits upon request, and this could cause problems with many components of the system. Ms. Butler said the apportionment section dealing with an employee reaching maximum healing would catch an employee between insurers. She handed out a deposition from a case the State Fund litigated (Exhibit #3). She said other portions of the apportionment sections were confusing, and could greatly increase litigation. She pointed out that putting the panel back in could slow the system there. She said there was unclear language about pre or post-maximum healing, and stated that the apportionment would create more problems than it would solve.

Representative Chase Hibbard, House District 46, Chairman of the House Select Committee on Workers' Compensation, told the Committee the area of apportionment had been taken out of HB 622 in the select committee, only to be reinstated in House Labor and Employment Relations. He said there were many problems with the apportionment section, as well as a conflict between the apportionment language and the preexisting condition language in HB 361. He suggested deleting the apportionment in HB 622 and working on it in the interim, because there were valid parts of the ideas.

Representative Jerry Driscoll, House District 92, told the Committee the attorneys testifying were worried about lump summing of medical benefits because it was not in the best interest of the worker, but it was the same attorneys who put a 60 month cap on medical benefits. He said these attorneys were also complaining about the temporary partial benefits. He stated currently unless the employer would pay 100 percent of the injured worker's pre-injury benefits, the worker did not have to go back. HB 622 allows for the employer to find a job that the injured worker could do, the worker could go back to work and receive medical and wage loss benefits while working. He said in the apportionment section, dividing liability between insurers of repetitive motion injuries and occupational disease. Carpal Tunnel takes several years to develop, yet without apportionment, when the condition shows up, the present employer must pay the full cost.
Representative Driscoll said one employer used sick leave to keep health insurance for families of employees. He said what happened, was that if sick leave was used up, the injured worker could still draw up to ⅔ of the pre-injury wage not to exceed $349.00 per week. He said the sick leave section attempted to allow employees with sick leave or vacation time to use it while drawing temporary partial or total so they can keep the health insurance for their families and supplement their income.

Jacqueline Lenmark, American Insurance Association, told the Committee AIA thought if HB 622, HB 347, and HB 361 were all passed, a successful workers' compensation reform package would be enacted. She said AIA supported the fraud provisions in HB 622, and explained that when Senator Harp chaired a subcommittee of the Governor's Workers' Compensation Task Force, that

committee unanimously recommended the provisions contained in sections 11 through 19 of HB 622. She asked the Committee to restore the language amended out in the House in section 18, page 46. She explained the language required that lawyers who practiced workers' compensation law advertise workers' compensation law as an area of practice, and in that advertisement state that fraud in the workers' compensation system is illegal. She said the provision was passed unanimously by the Governor's task force, and was stricken because of a misunderstanding. AIA supported the large deductibles in section 10 as a mechanism to allow employers to quasi self-insure. She said the worker would be protected as well under this provision as under regular workers' compensation coverage. She explained that the provision in section 10 was optional to the employer and the insurer, and would encourage the reentry of private insurers into the Montana market. Ms. Lenmark voiced AIA's support of the group discount section of HB 622. She handed out drafted amendments (Exhibit #4), and other informational articles and papers (Exhibits #5, #6, #7).

Bob Emerson, Montana School Boards' Association, told the Committee the concerns the Association had were with regard to section 22, the augmentation of temporary total disability benefits. He said this would be a disincentive to workers to return to work and that it presented the possibility of double dipping in the system.

Russell Hill, Montana Trial Lawyers Association (MTLA), said MTLA had concern with apportionment as a terrible, complex, and exploited provision in HB 622. He said from the workers point of view, the best thing to happen would be apportionment would cause massive and lengthy litigation. He stated that what was more likely to happen is the worker could not afford an attorney, and insurance companies would play "keep-away" with the benefits that employee is entitled to. He pointed out that on page 27, lines 5 and 6, the term "objective medical findings" was used, but there was no definition.

Mike Micone, Montana Motor Carriers Association (MMCA), told the Committee he agreed with the AIA amendments (Exhibit #4). He said MMCA supported sections 22 and 23, dealing with the group policies. He said these sections would allow small employers to join together in a group and apply to an insurer for group discounts. He said this was a benefit to each of the individual employers, and also to the insurer. The group would have to submit a plan to be approved, and would have to function as the provisions provided. He said HB 163, the safety bill, would require each employer to have a safety program, and report to the insurance commissioner how that safety training and other safety issues in the workplace would work. He said this was a benefit to the insurer. The deductible with the group plan would be a benefit to the State Fund because it would encourage private companies to start writing workers' compensation insurance in Montana. He offered a technical amendment (Exhibit #8).

Bill Crevello, Rehabilitation Association of Montana, said the association supported Representative Cocchiarella's amendments that would provide appropriation and responsible notification to workers of their benefits.

Russ Miller, F.H. Stoltz Land and Lumber, said F.H. Stoltz was self insured. He said the temporary partial issue in HB 622 was good, and noted that apportionment was also a worthy issue. He said ADA was making employers hire injured workers.

Daryl Holzer, Montana State AFL-CIO, said the best part of HB 622 was the new category of temporary partial disability benefits. He told the Committee encouraging people to get back to work was very important, as most every person on workers' compensation wanted nothing more than to get back to work.

Opponents' Testimony:

Norm Grosfield, an attorney in Helena, said he was an opponent because he was concerned about the apportionment section. He told the Committee the major problem with allocating liability was with cases that have been settled out. He asked if this section meant if a preexisting case had been settled out, then the worker would not be entitled to anything, or only a small portion. He said in 1991 he was involved with creating legislation for a bonafide rehabilitation program, which was passed. In HB 622, there is a provision to restrict settling out rehabilitation benefits. He said his concern was that this would require the insurance company to restrict its options. If it did not want to settle out rehabilitation benefits, then it would not have to, but the decision should be made through discussion between the employee and the insurer. He handed out an amendment to this section (Exhibit #9).

Informational Testimony:

None.

Questions From Committee Members and Responses:

Senator Bartlett asked Jim Puttman if the intent of the temporary partial section was to allow a worker who was able to return to work part-time, but was not yet able to work full-time, would not be eligible for that provision. Mr. Puttman answered this was not the intent. He said anyone who can not go back to work at the same wages or higher wages at the time of injury would be eligible for temporary partial disability.

Senator Harp asked Daryl Holzer if the language on pages 8 through 12 would allow the use of the Taft-Hartley Fund. Mr. Holzer answered this language would, and it was a very important protection for the workers.

Senator Aklestad asked Representative Ewer about the temporary partial disability section of HB 622. Representative Ewer said the main intent of the temporary partial disability benefits was that these benefits would be an incentive to get injured workers back into the workforce as quickly as possible.

Senator Towe asked Representative Ewer to explain the purpose of the sick leave provisions in HB 622. Representative Ewer stated the purpose was to allow an injured worker to receive sick leave benefits while receiving temporary partial or temporary total benefits, and to augment income in this manner.

Closing by Sponsor:

Representative Ewer closed, saying HB 622 would provide injured workers with incentives to return to work, would encourage private insurers to start writing workers' compensation insurance in Montana. He said he would resist putting rehabilitation back in HB 622.

HEARING ON HB 361

Opening Statement by Sponsor:

Representative Chase Hibbard, House District 47, told the Committee HB 361 provided on pages 4 and 5 that there be objective medical findings that an injury was legitimate before benefits could be awarded. He said HB 361 also provided that the work related injury be the major contributing cause of that injury to have benefits awarded. He explained if a worker had a preexisting bad knee, and then had a back problem, if the knee is found to be the major contributing cause of the bad back, then the back injury would not be compensable. He said that if there was a 0.10 or greater percentage of alcohol in the blood, the alcohol would be considered the major contributing cause under HB 361. There needed to be a preponderance of existing medical evidence to deny claims to an injured worker. He said HB 361 would level the playing field for the insurers and medical providers in the workers' compensation system.

Proponents' Testimony:

Bob Chambers, a surgeon in Great Falls, handed out informational papers (Exhibit 10 through 10d), and explained them. He said as a doctor he had people who came to him with pain that was not provable by any objective medical basis. He told the Committee benefit for pain may lead to pain, and pointed out the first cartoon as an example (Exhibit #10).

Tim Wiell, a medical doctor, told the Committee that HB 361 would defeat the psychopathology of pain. He encouraged passage of HB 361.

Nancy Butler, State Fund, rose in support of HB 361, saying it

ROLL CALL

SENATE SELECT COMMITTEE ON Workers' Compensation **DATE** 4/02/93

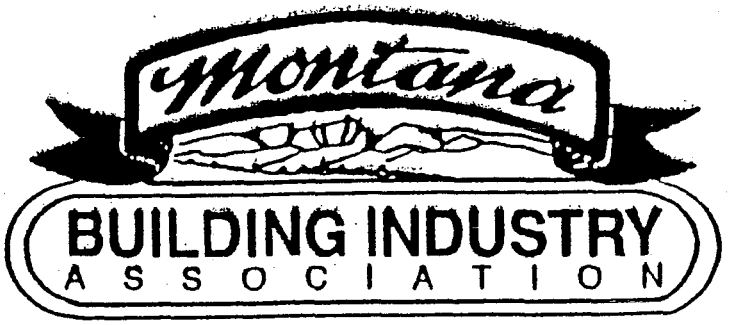
NAME	PRESENT	ABSENT	EXCUSED
Senator Towe	X		
Senator Forrester	X		
Senator Bartlett	X		
Senator Wilson	X		
Senator Burnett	X		
Senator Lynch	X		
Senator Aklestad	X		
Senator Fritz		X	
Senator Hockett	X		
Senator Hertel	X		
Senator Harp	X		
Senator Keating	X		
		/	

Attach to each day's minutes

ebuilders Assoc. of Billings
7533

Montana Home Builders Assoc.
3181

lt Falls Homebuilders Assoc.
HOME



Flathead Home Builders Assoc
752-2522

Missoula Chapter of NAHB
273-0314

Helena Chapter of NAHB
449-7275

Nancy Lien Griffin, Executive Director
Suite 4D Power Block Building • Helena, Montana 59601 • (406) 442-4479

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 1
DATE 4/02/93
BILL # HB 622

HB 622

Recommend:
DO PASS

Mr. Chairman: Members of the Committee:

I am Harlee Thompson a delegate from the Montana Building Industry Association to the Coalition for Worker Compensation System Improvement. (CWCSI)

The Coalition for Worker Compensation System Improvement supports Hb 622 in its entirety. However the way subsection 2 in section 8 on page 27 is currently drafted the possibility exists that the insurer could be required to pay a greater benefit than is required under current temporary total disability rates. To eliminate this possibility we would like to amend as follows :

1. Page 27 line 12
   Strike: " Weekly compensation benefits "
   Insert: "The insurer's liability "

2. Page 27 line 18
   Strike: " The state's average weekly wage at the time of injury. "
   Insert: " The worker's Temporary Total Disability rate."

IMPACT ANALYSIS OF SECTION 8, PAGE 27, OF HB 622

Weekly Earnings	$200	$300	$400	$500
Estimated Deductions	15%	20%	25%	25%
Take Home Pay	$170	$240	$300	$375
Compensation Rate (TTD-66 2/3)	$133.33	$200	$266.67	$333.33

ESTIMATE RETURN TO WORK 1/4 TIME BEFORE MMI

Earnings	$50	$75	$100	$125
Estimated Deductions	15%	15%	15%	15%
Take Home Pay	$42.50	$63.75	$85.00	$106.25
Compensation Rate (Temp-Partial/-622) Difference Between Pre & Post Injury Earnings	$150	$225	$300	$349.50
Income Take Home Compensation to Employee	$192.50	$288.75	$385	$455.75
Take Home Pre Injury	$170	$240	$300	$375
Take Home Post Injury Per (622)	$192.50	$288.75	$385	$455.75
Increase Income	$22.50	$48.75	$85	$80.75
Employers Increased Comp Cost (622) Weekly over TTD	$16.67	$25.00	$33.33	$16.17

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION

EXHIBIT # 2

DATE 4/02/93

BILL # HB622

IF HB 622 TEMPORARY PARTIAL PROVISION IS CHANGED TO 2/3

Weekly Earnings	$200	$300	$400	$500
Take Home Pay	$170	$240	$300	$375

RETURN TO WORK 1/4 TIME

Earnings	$50	$75	$100	$125
Take Home Pay	$42.50	$63.75	$85	$106.25
Wage Loss	$150	$225	$300	$375
Compensation Rate 2/3 of Difference	$100	$150	$200	$250
Take Home Compensation & Pay	$142.50	$213.75	$285	$356.25
Loss of Take Home Pay	$27.50	$26.25	$15.00	$18.75
Employer's Compensation Savings	$50	$75	$100	$99.50

House Bill 622

by George Wood
MONTANA Self Insurers Assn.

Page 27 line 13
after the word be
insert: "66⅔ percent of"

Pages 52 and 53

Strike sections 24 and 25 in their entirety

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 2a
DATE 4/02/93
BILL # HB 622

Q. Doctor, is there any recognized -- and by recognized, I mean within your profession -- objective basis for assigning percentages of causation in these cases?

A. I don't believe that there is.

Q. Is it possible, therefore, for different physicians to come up with different percentages in answer to the kinds of questions Mr. Bach was propounding?

A. I have no doubt that other physicians with the same training and experience that I have in these matters may come up with a different set of numbers.

Q. Is it fair to characterize the percentages you assigned as an educated guess?

A. It is fair to characterize them in that fashion, counselor.

Q. And so that I understand, although it is clear that the cervical pathology which was evidenced in '86 and '87 did not exist in 1979, your testimony is that 30 percent of that pathology can be attributed to the 1979 accident?

A. I think it would be impossible to discount the possible effects of the '79 injury, and my best educated guess is that it's contributed to 30 percent of his most recent neck problems.

Q. As to his lumbar problems, the 1979 accident appears to be neutral; am I correct?

A. That is correct.

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 3
DATE 4/02/93
MARTIN-LAKE & ASSOC. BILL # HB 622

Amendments to House Bill No. 622
Third Reading Copy

Prepared by Jacqueline Lenmark
American Insurance Association
April 2, 1993

1. Page 2, line 19
Following: "the"
Strike: "department"
Insert: "commissioner of insurance"

2. Page 46,
Following: line 10
Insert: (2) A PERSON LICENSED TO PRACTICE LAW IN MONTANA OR A MEDICAL CARE PROVIDER WHO ADVERTISES SERVICES OR FACILITIES WITH THE INTENTION THAT A WORKER USE THOSE SERVICES OR FACILITIES WITH REGARD TO AN INJURY OR ILLNESS THAT IS COMPENSABLE UNDER CHAPTER 72 OR THIS CHAPTER AND WHO FAILS TO ANNOUNCE IN THE ADVERTISEMENT THAT FILING A FRAUDULENT CLAIM IS THEFT, AS PROVIDED IN 39-71-316, IS SUBJECT TO THE PENALTY IN SUBSECTION (3).
Renumber subsequent subsection.

3. Page 49,
Following: line 19
Insert: (3) "COMMISSIONER" MEANS THE COMMISSIONER OF INSURANCE.

4. Page 49, lines 17, 22, 25,
Page 50, lines 5, 9,
Page 51, line 5,
Strike: "department"
Insert: "commissioner"

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 4
DATE 4/02/93
BILL # HB 622

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 5
DATE 4/02/93
BILL # HB 622

Backgrounder on Workers' Compensation Large Deductible Plans

October 25, 1992

What are large deductibles?

A new insurance product for workers' compensation coverage is now available from many insurers - large deductible plans. Workers' compensation coverage is mandatory for most employers. Traditionally, workers' compensation insurance was available only with first dollar coverage. Employers willing to take the entire risk could self-insure -- if they qualified. However, there was no insurance product for employers who wanted to take some of the risk. Large deductible plans fill this gap.

Why large deductibles should be available

There a number of reasons to allow authority for large deductibles.

✓ *Responsive to demand* - employers want the flexibility to choose taking part of the risk without having to take the entire risk, while continuing to receive professional claims, loss control, and other services from the insurer. Unlike self-insurance, a large deductible protects the employer against catastrophic loss.

✓ *Security for injured workers* - large deductible plans provide for direct payment of benefits by the insurer, including the deductible amount, subject to reimbursement from the employer. These plans provide workers and state officials the confidence of knowing that benefits will be paid as required. The insurer, not the injured worker or the state, takes the risk of collecting amounts owed by the employer.

✓ *Safety and return to work incentives* - by taking part of the risk, the employer has additional financial incentive to prevent injuries. At the same time, the deductible gives employers strong financial incentive to better control claims costs through effective return to work programs.

✓ *Promote insurance availability* - large deductible plans enable insurers to compete against self-insurance. Insurance is subject to taxes and assessments that generally do not apply to self-insurance. Most states levy a premium tax on all insurance policies. In addition, in many states

insurers are assessed to pay for any deficits in the workers' compensation assigned risk pool. The assessment, called a "residual market load" or RML, is levied on each insurer in proportion to its voluntary workers' compensation business - in effect, a subsidy from the voluntary market to the assigned risk pool. Premium taxes and the RML can create a significant competitive disadvantage for insurance, ~~because~~ because self-insurers are exempt. An insurance policy written with a large deductible has a smaller premium and thereby a reduced tax burden and RML - which may make it financially attractive to write compared to first dollar coverage for the same employer.

How do large deductibles compare to retrospective rating?

Most states already permit another form of loss-sensitive workers' compensation insurance coverage - retrospective rating. The question arises how large deductibles differ from "retro" plans. Retrospective rating plans provide a range - a minimum and maximum premium - with the over-all cost to the employer determined within that range based on the employer's claims experience. A large deductible plan is like a retro in the sense that the cost is sensitive to the employer's experience. However, it is more flexible, allowing an employer to attain greater savings by bearing more of the risk than would be allowed under a retro plan, while providing fully insured protection for losses over the deductible amount. Unlike a retro, the price is determined by the cost of the insured amount, plus actual claims costs (including an agreed allowance for the cost of claims adjustment and administrative fees for handling the account). Some large deductibles have no cap, but are based on the employer's losses. However, unlike self-insurance, these deductible plans require the insurer to pay the benefits and then seek reimbursement from the employer.

How are large deductibles regulated?

Insurers are permitted to use large deductible plans in most jurisdictions. Insurers wishing to use these plans file them with insurance regulators. In a few states, however, the insurance rating law or workers' compensation act has been interpreted to prohibit or severely restrict their use. For example, some states that expressly permit small deductibles at various dollar amounts - typically $500, $1000, $2500 - interpret the law to preclude large deductibles.

How do large deductibles affect state assessments and premium tax collections?

Normally state assessments and premium taxes are levied on insurance premiums on a *net* basis - after application of any price adjustments, including the workers' compensation experience

modifier, discounts, rate deviations, and other price adjustments. This practice applies equally to adjustments recognizing the price effect of the deductible.

In states where assessments are levied equally on insurers and self-insurers, there is no competitive advantage for self-insurance. For example, Idaho imposes a special assessment on insurers and self-insurers, with the proceeds dedicated to finance the Industrial Commission, which administers the state workers' compensation act. When assessments apply equally to insurers and self-insurers, AIA recommends that states use losses rather than premiums as the base, to help distribute costs fairly and accurately.

How do large deductibles affect the ratemaking process?

Insurers report losses on an aggregate basis, including amounts paid under deductibles. Reporting on a gross basis is needed to protect the integrity of the experience rating system and to maintain complete and accurate data to establish rates. Without this complete information, it would be difficult to know how to price the coverage with and without the deductible amount.

What are the arguments against large deductibles?

- Some insurers have objected to use of large deductibles by their competitors on grounds they reduce or redistribute the assessment base for the assigned risk pool as well as the premium tax base. However, they do not make a convincing case that large deductibles should be treated on a different basis from other competitive pricing adjustments and the uniform experience rating plan, which affect the base as well. Moreover, some employers would undoubtedly drop out of the assessment base entirely by self-insuring, if the pricing flexibility of large deductibles were not available. With respect to these employers, large deductibles actually preserve or expand the base.

- Some insurers also argue that large deductibles may give an advantage to their competitors who can afford to pay the deductible amount and collect back from the policyholder later. However, this is not a strong argument, because any insurer may extend credit to its policyholder over payment of premiums. An insurer wishing to use a large deductible plan may negotiate with its policyholder the schedule for collection of amounts paid under the deductible and any security requirements. In practice, insurers using large deductible plans establish dedicated policyholder-funded accounts and/or negotiate funding arrangements to use policyholder supplied resources to pay claims and expenses, thus there really is no significant extension of credit.

► Large deductibles will be used disproportionately by employers with good experience, constricting the first dollar coverage pool to smaller businesses and those with bad experience. Insurance may become prohibitively expensive for those remaining employers using first dollar coverage. However, this argument assumes that employers using deductibles would have remained in the insurance market. Moreover, to the extent employers with deductibles have better loss results, it is because they devote more attention to safety and make greater use of return to work programs to control their losses. Consequently, they *should* pay rates reflecting their true insurance exposure.

► Insurance regulators in a few states have raised solvency questions. If the deductible amount is very large and competitive pressures in the insurance market place are intense, they express concern that some insurers may take unacceptable risks. AIA recommends that insurance regulators address this concern in the filing process by refusal to approve plans for those few insurers whose financial condition gives rise to such concerns or by requiring that such insurers obtain adequate financial security for the deductible amount.

► Some insurance regulators have expressed concern that large deductibles will materially reduce the premium tax receipts used to finance insurance regulation, even the burden of insurance regulation is no smaller. For example, regulators must make sure insurers are handling the deductible amounts properly and reporting them correctly for ratemaking. However, if the employer were to abandon insurance and self-insure, there would be an even greater reduction in tax receipts. Where the adequacy of adequate funding for insurance regulation is a concern, AIA supports reaching an accommodation if necessary to gain approval of otherwise acceptable deductible legislation.

► In a few states, workers' compensation agencies have raised objections that large deductibles are not permitted because they do not satisfy workers' compensation self-insurance laws. However, large deductibles are not self-insurance because they are used for employers who want to take *part* of the risk and because the insurer is responsible for payment of claims, including the deductible amount.

Security for deductible

A few regulators have proposed regulation of the security for the deductible amount furnished by the employer. Because this question is normally addressed in the negotiations between insurer and policyholder, AIA opposes regulation of the form or amount of security. States require security for self-insured

employers, whose solvency is not regulated. Workers employed by insured employers with large deductible plans do not have the same risk as those employed by self-insurers, because benefits are guaranteed by the insurance carrier, whose solvency is regulated by state insurance departments. Unlike self-insurers, insurers have strong financial incentive to require adequate security from policyholders - an insurer will not make the deductible plan available unless it is confident of being reimbursed. Therefore, it is unnecessary to regulate the solvency of the individual employer using a deductible plan. Consequently, AIA opposes prescriptive criteria for the form or amount of the security.

Size of deductible amount and size of employer

In a few cases, regulators have recommended that large deductible plans be available only to employers whose premium is over a threshold. AIA does not advocate there be any minimum threshold but believes that if one is adopted it should not unduly restrict the flexibility to use these plans and that it should operate with a lower threshold for multistate employers.

AIA is opposed to arbitrary quotas restricting the number or premium volume of large deductible plans. Insurers should be permitted to offer these plans to all qualified policyholders interested in them.

AIA recommends that large deductibles be permitted in amounts negotiated between the employer and insurer. For employers interested in large deductibles, there is an arm's-length business relationship between the employer and the insurer which justifies greater flexibility.

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prepared by
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SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 6
DATE 4/02/93
BILL # HB 622

Are Large Deductible Plans a Way Out of the Workers' Compensation Crisis?

By Arthur Gilbert, CPCU
Aetna Senior Account Executive, National Commercial Accounts
from R.O.M. Risk Management Section Quarterly

Over the past one and one-half to two years, several major writers of workers' compensation insurance have introduced large deductible workers' compensation plans and have actively solicited approval of such plans from insurance regulatory bodies of nearly every state. Where approval of these plans has been received, compensation large deductibles have been aggressively marketed to brokers and risk managers as a way of dealing with several of the shortcomings of the current workers' compensation market. The questions each risk manager must ask are: Will a large deductible plan be right for my company? Is it merely a gimmick, or is it something really worth my attention?

A New Application of an Old Concept

In order to answer these questions, we must first look at those characteristics of large deductibles which make them a workable option. After all, deductibles have been around for almost as long as insurance policies, and the idea of a large deductible as a loss-responsive rating plan is not new. Large deductible plans have been used successfully for decades as an alternative to retrospective rating for liability lines. Such plans often present unique advantages, both to the client and to the insurance carrier, which can make them highly attractive.

To define what we are discussing, in the casualty lines of insurance, any deductible of $25,000 or more is usually considered a "large" deductible. From a practical standpoint in today's market, however, a deductible of $100,000 per occurrence or more is common. Under a large deductible plan, the insurance carrier initially charges the client an up-front "handling fee" (deductible policy premium). This premium includes the carrier's expenses for overhead, profit, taxes, bureau fees, and the like. There is also a premium for coverages the carrier is providing in excess of the deductible amount to the policy limit of liability.

Beyond this initial handling fee, the client agrees to reimburse the carrier for losses up to the amount of the deductible selected. The carrier retains the responsibility for handling and payment of all claims from first dollar, with the client reimbursing the carrier for the amount of any loss within the limits of the deductible. In addition to the loss amount itself, the carrier may require the reimbursement of claim-handling expenses. Allocated expenses — those identified with the handling of a specific claim — are generally included within the loss reimbursement, while general claim-handling expenses are handled through a loading in addition to each reimbursement. Losses and claim-handling costs are usually reimbursed on an "as paid" basis. That is, the carrier makes a payment to a claimant and, within a specified time period, requests a reimbursement from the insured. Loss reserves are not subject to reimbursement.

Dual Advantages

The advantages to the insured lie in the cash flow provided. Most other loss-responsive rating plans, including retrospective rating, require reimbursement for paid losses and loss reserves. (Even if the client has a plan wherein only paid losses are reimbursed under a retrospective rating plan, the term of this deferment is usually only a few years.) Under a deductible rating plan, the client reimburses the insurer only for losses which are actually paid, and this reimbursement method remains as long as there are losses outstanding. For the average account, this will likely result in a more favorable cash flow pattern.

Conversely, the carrier enjoys advantages stemming from the fact that only the deductible policy premium (not loss reimbursements) is booked. This is important to carriers from the standpoint of policyholders, surplus requirements, and to carriers and insureds from the standpoint of premium taxes.

The Number One Issue

Workers' compensation has become the number one insurance issue for many businesses today. Ever-increasing loss costs, along with an overburdened assigned risk pool encumbered by individual state political and economic issues, have all contributed to the problem.

In the search for possible solutions, many risk managers are looking at self-insurance of workers' compensation in a way they would not have considered previously. However, self-insurance is not for all risks. Many states have strict financial requirements for self-insurance and the costs (often hidden) of loss control and claim handling must be provided and managed. There is also the potential of catastrophic workers' compensation loss for which insurance is essential. Often excess workers' compensation insurance is only available in a finite limit as opposed to a statutory limit provided by primary policies.

A Viable Alternative

Large deductible plans are a viable alternative to self-insurance, offering relief from many of the issues discussed, yet not creating a new set of dilemmas of their own. Under a large deductible workers' compensation plan, the insurance carrier retains all obligations under the law with regard to claim handling and payment, so the claim-handling mechanism remains fully in place. Unlike a retrospective rating plan, losses reimbursed under the large deductible plan are not considered premium and, thus, are not subject to premium tax. Eligibility for large deductible plans varies by state and by carrier, although, in general, an account producing $500,000 in annual premium may qualify. Finally, the plan utilizes a standard workers' compensation policy coverage form, so there is no difference in the statutory coverage provided under the deductible plan from that provided under other types of commercial rating plans. Thus, the need to consider excess insurance to cover statutory obligations in the event of a catastrophic situation is eliminated.

Limitations

Carriers that offer a large deductible plan stress its appeal, especially in comparison to other rating plans, as an alternative to self-insurance. Yet the large deductible is not without its limitations. First of all, the plan is not approved in all states. For an account with multi-state exposures and planning to insure all exposures commercially, some states may be written under a deductible plan, while others must remain on some other type of plan. The costs of administering such a split program may be higher than those of a single program. However this situation would be no different if there were a decision to partially self-insure. Second, there may be security requirements for a deductible plan, since most carriers will request security to cover losses. The amount and type of security will vary by carrier and type of plan filed. Finally, since deductibles are reimbursed on paid losses, a long and, perhaps, irregular payout pattern may be the rule, giving rise to the need for an in-house "funding" mechanism.

A Mixed Reception

To date the various state regulatory bodies have given large deductible programs a mixed reception. A study conducted by the Missouri Insurance Department in August 1990, and reported by the National Association of Insurance Commissioners (NAIC), noted that many state regulatory authorities saw large deductible plans as useful alternatives to self-insurance, but expressed specific concerns. Among those concerns were compliance with statutory requirements that the insurance carrier not be allowed to abdicate its responsibilities regarding payment of workers' compensation claims, and impact on statistical reporting.

The underlying premise of the large deductible plan is that a carrier retain the full responsibility for handling and payment of claims. In this respect, the large deductible is more of a reimbursement agreement than what is traditionally thought of as a "true" deductible. Likewise, under the large deductible format, the carrier is required to report fully all losses, including those within the deductible layer, and losses within the deductible layer are included in the calculation of an account's experience rating. These provisions differ sharply from those of small deductible plans, which are currently available in several states.

Large Deductible Plans

(continued from page 33)

These latter plans represent true deductibles, since they generally apply to medical benefits only and are payable by the employer directly, and losses within these deductibles are not included in statistical reporting for experience rating.

While some states have rejected the use of deductible rating plans as being contrary to state laws, a number of states have either already enacted or are now considering modifications to state statutes to permit large deductible rating plans. The fact is that many states are recognizing the need for reform and are looking favorably on any plan which appears likely to generate improvement in the overall situation.

A Long-Term Solution

The large deductible plans that are being offered represent hope for risk managers trying to deal with some of the worst features surrounding the current workers' compensation crisis. However, it cannot be expected that any one rating plan can offer a total solution. The fact that carriers and state regulators have been receptive to the concept of deductibles in workers' compensation indicates an intense desire to change the overall picture for the better. The ultimate solution lies in reform of the workers' compensation system through cost control, rate adequacy, and depopulation of the residual markets. A concerted effort in support of reform on the part of all in the industry is the only permanent solution. □

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Author's note

Since this article was originally written the interest in workers' compensation deductible plans has continued to increase. Aetna has filed two large deductible programs. One, in Farmington Casualty Company, is intended for National Commercial Accounts generating $500,000 or more in manual premium, and has been approved in about 30 states. The other, in Aetna Casualty and Surety, is for Standard Commercial Accounts generating $100,000 or more in manual premium. It is approved in about 22 states at the time of this writing.

The reference to a study commissioned by the Insurance Department of the State of Missouri is in no way intended to imply any particular predisposition either for or against the principle of deductible compensation insurance on the part of that regulatory body. Earlier this year, Missouri enacted legislation permitting carriers to offer deductibles to insureds.

The article states that small deductible plans differ from large deductible plans in that losses within small deductibles are not reported statistically or for experience rating. This point requires further clarification. The National Council on Compensation Insurance notes that of the nearly 20 states which have enacted small-deductible plans, about half require that losses be reported net of employer reimbursement, while the other half require reporting on a gross basis. NCCI staff members are currently studying the potential impact two different methods of loss reporting may have on the experience rating system, with the objective of minimizing any possible rating distortions. □

Agency Earns Special Thanks

The General Insurance Agency of Culpeper, Virginia, recently received the kind of thank-you note that puts insurers and agents in touch with just how important their work is.

The letter, from St. Stephen's Episcopal Church Rector Rev. H. Vance Mann III, a client of General Insurance, was an expression of gratitude for the support and assistance the agency had given the church when it was heavily damaged during a storm.

The letter, which General Insurance re-ran in its client publication, says:

"We have received hundreds of compliments from persons in the community about how handsome our reconstructed church looks after the extensive storm damage in July 1990. It's hard to believe it is the same church, and that the mess created by the storm could have been resurrected. Much of the credit for this is due to you and your agency and Bob Shiflet of Aetna.....

"...Your compassionate concern for our situation helped bolster our hope and determination to keep going. You constantly kept in touch with us to make sure we were getting the support and skilled help we needed. Consequently, repairs were made more quickly than I and others ever expected." □

CSRs Learn PRISMS

More often than not, customer service representatives are the public's first contact with a company. CSRs are also the major source of support for agents working to meet the needs of their clients.

With that in mind, Aetna's New York City office sponsored a seminar to expand and enhance the skills of the CSRs in its territory.

Called PRISMS for CSRs, the one-day course was held in the Aetna training room in the World Trade Center. More than 70 CSRs attended the seminar, which was offered for the first time last spring, according to Kendra J. Carson, homeowners sales representative in Aetna's New York City office.

The seminar covered communications, organizational skills, processing functions, errors and omissions and professional image.

"The program helped me realize that although I'm organized, I'm not as thorough as I could be," said Marygene Anderson, personal lines manager of Richards and Fenniman Agency. Nancy Anatra, a former Aetna employee who is now a CSR, said "The seminar really helped to change my perspective. I thought company first, agency, then client. Now I realize the client is always number one." □

6
4-2-93

WORKERS COMPENSATION DEDUCTIBLE CONSIDERATIONS

EMPLOYER INCENTIVES

The cost differentials between insured and self insured programs are increasing, and they provide definite incentives for employers to self insure or find some other means to self fund a large amount of their Workers Compensation benefits. These cost differentials are principally driven by the following:

1) The statutory surplus required to guarantee benefits is becoming increasingly more expensive. A large Employer's internal rate of return is invariably such as to show at least a 5% advantage for self funding.

2) The Federal Tax Reform Act of 1986 requires that Property and Casualty loss reserves be discounted. The impact of this on Workers Compensation Insurers is a 4% increase in costs. There is no impact on a Self Insurer.

3) Insurer taxes and assessments have all increased significantly. Insurers now pay from 1% to 10% of premium in taxes, assessments and fees. Self Insurers pay 1% to 5% less of imputed premium - an invariably lesser base as well as a lesser rate.

4) Residual market costs for Workers Compensation Insurers have exploded to 16% of voluntary premium countrywide. Self Insurers do not participate and so, pay nothing.

With as much as a 25% cost disadvantage, conventional insurance plans - either guaranteed cost or loss sensitive - are no match for self insurance. However, large deductible plans can narrow the cost differential sufficiently to provide a reasonable alternative. This is accomplished by reducing the premium upon which these costs are based.

In addition, all the guarantees and services of conventional insurance programs are provided as a further incentive. And finally, by remaining in the insurance system, the necessary framework is maintained for the employer to exercise various other insurance options in the future.

UNDERWRITER INCENTIVES

Survival in any business is predicated on response to customer preference. Employer demand for traditional insurance guarantees and services packaged with the cost savings of self funding is the underwriter's principal incentive.

Surplus is a scarce resource. If it can be used to underwrite more business and provide comparable security, an increase in productivity results. The same is true for loss reserves particularly now that they must be discounted. The result can be a more attractive return from a line of business which has grown increasingly less attractive.

CLAIM HANDLING

The hallmark of Workers Compensation Insurance is the insurer's direct and impartial relationship with and responsibility to the injured worker. Regardless of how the employer funds the benefits, this responsibility and relationship must be maintained for a deductible plan to be a bona fide alternative to conventional insurance. So the insurer must not only adjust all claims from first dollar, but be the sole guarantor of all claims as well.

REIMBURSEMENT PROVISION

Since the insurer is solely responsible for claim payments the standard Workers Compensation Policy must be used as the coverage vehicle. An endorsement provision for reimbursement of deductible losses by the employer must be established in such a manner as to provide no greater threat to benefit guarantees than non payment of premium would under conventional insurance.

SECURITY

The employer's reimbursement agreement serves the same purpose as respects losses within the deductible that surplus and loss reserves would serve otherwise. It must fully support the insurer's financial capacity to pay claims. Therefore, a cash deposit is required to fund current claim payments and an irrevocable letter of credit on a bank acceptable to the insurer is required to fund ultimate future claim payments.

APPLICATION

In order to respond to risk management principles, required reimbursements must be reasonably predictable, protect the employer against catastrophe and afford the opportunity to manage the risk. Including allocated loss adjustment expense in the definition of deductible loss provides for risk management involvement. Applying the deductible limit to all injuries arising from a single accident and each person for disease, protects against catastrophe, and is consistent with the standard employers liability approach.

EXPERIENCE RATING

EXHIBIT 7
4-2-93
HB 622

Standard premium is the point of reference by which the cost of all Workers Compensation benefit funding arrangements can be compared. It represents the established price for a fully insured program on a guaranteed cost basis; and, given reasonable rate adequacy, provides a basis for underwriting a risk. Thus the integrity of experience rating should be maintained so as to provide the basis for future insurance options.

PRICING

The premium credit for a deductible should identify that portion of an individual employer's premium which is designed to fund losses within the deductible limit. Therefore it should be applied to the employer's otherwise applicable standard premium.

The remainder of the standard premium should be unaffected by the deductible credit since the guarantees and services funded by the remainder are unchanged. So premium discount should also be based on the otherwise applicable standard premium.

Deductible plans are designed to encourage more effective employer implementation of cost control measures. To the extent that these are implemented there should be a means for recognizing their anticipated result. Parameters should be established as well as the means for regulatory oversight.

DATA REPORTING

Current data calls provide sufficient information to establish proper deductible credit formulas. So long as unit statistical data is reported gross, ignoring deductible impact, existing rate making and individual risk experience rating mechanisims will be preserved. Allowing net losses and credited premiums to impact rate making and experience rating will undermine each, and undermine the basis for underwriting flexibility which employers would want preserved.

ELIGIBILITY

We must be careful not to encourage the purchase of deductible coverage by employers who are neither sufficiently risk management oriented nor financially responsible. Those who would gamble that no losses would occur rather than prudently fund and manage them, will cause great grief to themselves and the insurance industry.

To the extent that political expectations will permit, eligibility requirements should discourage all but the relatively few employers who can effectively use the plan as part of an overall program to manage workers compensation benefit costs.

Excess Loss Premiums and Insurance charges based on industry claim data by state, provide the basis for a deductible credit formula sufficient to discourage those who should be discouraged. We should resist pressure to reduce these risk charges in an attempt to make the plan attractive to more employers.

DISCRIMINATION

Deductible Plans are designed to provide larger employers with the means for funding and administering their Workers Compensation benefits within the insurance system. We are convinced that involvement of these large employers in the system is critical to its continued viability. They not only provide needed funding but leadership and inovation as well.

The incentive for them to remain is partly based on reduced costs for programs funded by assessments against premium. Otharwise the incentive is for them to leave or stay out and provide no funding for the residual market deficit, no contribution to insurance industry surplus, no insurance guaranty fund support, and no taxes and premium based assessments. Those relatively few employers who can self fund will do it. The only question is whether they will do it within the insurance system and provide some support for it or self insure and provide none.

This could be perceived as discriminatory against smaller employers and their insurers who would have to share a larger proportion of the burden. However a broader question is whether its to the industry's advantage to have some participation from the larger employers or none. If it's none then the proportion for the smaller accounts is total and the actual cost is greater. If it's some then their actual cost is less and their proportion is less than total.

Amendment to House Bill No. 622
Third Reading Copy

Prepared by Mike Micone
Montana Motor Carriers Association
April 2, 1993

1. Page 50, line 15
Following: "state"
Strike: "."
Insert: ","

2. Page 50, line 15
Following: ","
Insert: "Except that the state fund has the right to refuse coverage of a group and it's plan of operation but cannot refuse coverage to an individual employer."

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 8
DATE 4/02/93
BILL # HB 622

Norm Grosfield

Amendments to House Bill No. 622

1. Page 20, lines 17 and 18.
Strike: "AND ARE NOT SUBJECT TO THE LUMP SUM PAYMENT PROVISIONS OF 39-71-741"

SENATE SELECT COMMITTEE
WORKERS' COMPENSATION
EXHIBIT # 9
DATE 4/02/93
BILL # HB 622

DATE FRIDAY, APRIL 2, 1993

SENATE SELECT COMMITTEE ON WORKERS' COMPENSATION

BILLS BEING HEARD TODAY: HB 361 - Hibbard; HB 622 - Ewer

PLEASE PRINT

Name	Representing	Bill No.	Check One: Support	Oppose
Tim Weill MD	self	361	✓	
Jim Putman	CWCSI	361	✓	
" "	"	622	✓	
Ross Miller	F.H. Stoltze Land & Lumber	622	✓	
ROBERT LITAMBERS	SELF	361	—	
Darrell Holzer	mt. St. AFL-CIO	361		✓
Darrell Holzer	mt. St. AFL-CIO	622	✓	
Nancy Butler	State Fund	361 622	✓ ✓	
Jim Tutwiler	MT Chamber/MT RETAIL ASS'N	361	✓	
George Wood	Mt. Self Insurers Assoc.	~~361~~ ~~622~~	~~✓~~ with amendments	
Mike Micone	MTCA	361 622	X	
~~Ann~~ Jacqueline Lenmark	Am. Ins. Assoc.	361 622	X	
Jan VanDyke	self	361 622		✓
Nancy Butler	State Fund	361	✓	
Hank Thompson	MBIA	361 622	✓ ✓	
Gary Willis	Montana Power Co.	622	✓ with Stat. amend.	

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

DATE FRIDAY, APRIL 2, 1993

SENATE SELECT COMMITTEE ON WORKERS' COMPENSATION

BILLS BEING HEARD TODAY: HB 361 - Hibbard; HB 622 - Ewer

PLEASE PRINT

Name	Representing	Bill No.	Check One: Support	Check One: Oppose
Don Allen	CWCSI	361 622	✓	
Jamie Doggett	MT Cattlewomen	361	✓	
Vern Cole	MMIA-MSCIA-MACO	361	✓	
Russ Ritter	Wash Corp	361 622	✓	
Norm Grosfield	Self	361 622		✓

VISITOR REGISTER

PLEASE LEAVE PREPARED STATEMENT WITH COMMITTEE SECRETARY

MINUTES

MONTANA SENATE
53rd LEGISLATURE - REGULAR SESSION

SELECT COMMITTEE ON WORKERS' COMPENSATION

Call to Order: By Senator Tom Towe, on April 6, 1993, at 3:05 PM

ROLL CALL

Members Present:
Sen. Tom Towe, Chair (D)
Sen. Gary Forrester, Vice Chair (D)
Sen. Gary Aklestad (R)
Sen. Sue Bartlett (D)
Sen. Jim Burnett (R)
Sen. Harry Fritz (D)
Sen. John Harp (R)
Sen. John Hertel (R)
Sen. Bob Hockett (D)
Sen. Tom Keating (R)
Sen. J.D. Lynch (D)
Sen. Bill Wilson (D)

Members Excused: None.

Members Absent: None.

Staff Present: Susan Fox, Legislative Council
Kelsey Chapman, Committee Secretary

Please Note: These are summary minutes. Testimony and discussion are paraphrased and condensed.

Committee Business Summary:
Hearing: None.
Executive Action: HB 361, HB 13, HB 622, HB 504

EXECUTIVE ACTION ON HB 361

Motion:

Senator Lynch Moved HB 361 BE NOT CONCURRED IN.

Discussion:

Senator Harp spoke against the motion, saying he would like to preserve the portion of HB 361 that dealt with objective medical findings. He said that almost 68 percent of minor injuries including sprains and back pain, are unverifiable injuries. He

Senator Lynch moved HB 13 BE CONCURRED IN AS AMENDED. The motion CARRIED UNANIMOUSLY.

Senator Harp was assigned to carry HB 13 on the Floor.

EXECUTIVE ACTION ON HB 622

Discussion:

The amendments (hb062225.asf) were discussed. Senator Towe told the Committee the amendment dealt with the question of the injured worker not keeping a medical appointment, and thus losing benefits. He said it seemed there might be a confusion on page 15, lines 17 through 21 which states "if after medical examination the injured worker is released to return to work, the worker forfeits the right to any suspended benefits." Senator Towe asked what would happen if a worker, who did not comply with an initial request to see a doctor, went in for such an appointment and was determined to be fit to work. Under HB 622, the benefits were suspended. Senator Towe gave another example where a worker did not show up for an initial medical appointment, but goes some days later, and is found to be unfit to return to work. The worker would still lose benefits, because of the original suspension. Senator Towe said he thought the worker was released from receiving benefits on the day the worker failed to keep the medical appointment. He noted that if a worker does go to an appointment after this and is found to be unfit for work, the worker should not be penalized for that period of time between the missed and the attended appointments.

Senator Harp said the amendment was a "what-if" amendment, and added the language was clear in the Bill. He said he was confused as to what the amendment would do, and would vote against it.

Senator Towe reiterated his explanation of the amendment (hb062225.asf).

Senator Harp expressed that the phrase used was "unreasonably fails to keep a scheduled appointment". He said the person would have to miss an appointment without a valid excuse to have the benefits suspended.

Senator Keating said if a worker missed an appointment and was later found to be able to return to work, those benefits would be suspended. He stated this was clear language that did not need changing.

Senator Towe said the issue was if a worker missed a medical appointment, and is given another notice to come, and makes that appointment a month later whereupon the worker is not able to go back to work, the benefits have been suspended. Senator Towe said during the time the worker was not fit to work, the worker

should be able to claim benefits. The amendment said if after the medical examination the injured worker is released to return to work, the worker forfeits the right to any suspended benefits. If found unfit to work, the benefits are received.

Senator Harp said if an injured worker has been suspended for a year and then decides the benefits are needed, that claim should be questioned.

Senator Towe said HB 622 without the amendment says that if the worker fails to make the examination, the worker is presumed to have been ready to be released to go back to work. He said this protected the fund, but not the injured worker who may have a problem at a future time.

Senator Hockett said he did not see what was wrong with what HB 622 already provided for, and that "unreasonably" describes what the law should say.

Senator Keating stated if a person unreasonably fails to keep a scheduled medical appointment, it would generally be because the worker thinks that the doctor would release the worker to go back to work. He said this was the presumption in the Bill. If the worker did not show up, benefits were suspended. He noted that if the worker is examined at a later date and found fit to return to work, then the benefits remain suspended. Senator Keating said Senator Towe was trying to turn two ideas into one, which distorted the whole section.

Senator Towe said the intent of the amendment was that if a worker missed the first appointment, the benefits were suspended. He noted HB 622 did not say if the worker went to the next appointment the benefits would be reinstated. The problem is that even if the worker makes the next appointment ten days later, the suspension would continue until the worker goes back to work. Senator Towe said at the time the first appointment is missed, the worker forfeits all benefits, which is wrong.

Senator Towe said all he was suggesting was that after the medical examination the injured worker is presumed to have been released of benefits on the day the worker failed to keep the medical appointment.

Senator Harp clarified the word was not "appointment", but instead "appointments", which was critical.

Senator Towe said the amendment allowed for suspension of the benefits, but added if an appointment was attended, the worker would not lose the benefits from that point forward as the present language provides for.

Motion/Vote:

Senator Towe moved HB 622 be amended (hb062225.asf). The motion FAILED by a roll call vote, with Senators Harp, Hockett, Burnett, Aklestad, Hertel, Forrester, and Keating voting NO. Senators Towe, Bartlett, Lynch, and Wilson voted YES. Senator Fritz voted YES by proxy.

Discussion:

Senator Harp asked if amendment (hb062222.asf) was about apportionment.

Susan Fox clarified the amendment was about lump summing medical benefits. She explained the only change in section 5 was on page 18, line 14, which included the right to lump sum future medical benefits. The amendment would strike Section 5 in its entirety.

Senator Towe said section 5 would be stricken in its entirety, and the only thing to focus on was the language on page 18, line 14, and whether or not that language should remain in HB 622.

Senator Wilson said he would like to strike line 14, "including the right to future medical benefits for lump sum payments", as that could possibly preclude a claimant from receiving future medical benefits.

Senator Lynch said that was the purpose of the amendment.

Motion:

Senator Wilson moved the amendment (hb062222.asf) be adopted.

Discussion:

Senator Harp stated his support of Senator Wilson's motion. He said problems occured when medical benefits were lump summed, as there was no way to accurately predict future medical need. He said that the insurer and claimant should arrive at a reasonable settlement. He stated that medical never did stop under workers' compensation, which was a concern to the State Fund, PLAN 1's, and PLAN 2's. Senator Harp said he did not understand why these provisions had been put in the Bill.

Senator Hockett asked for clarification of the amendment. Senator Towe said Section 5 was being stricken because the only thing changed in the section from the regular codes was on page 18, line 14. The law would stay status quo with the amendment.

Vote:

The motion by Senator Wilson that HB 622 be amended (hb062222.asf) CARRIED UNANIMOUSLY, with Senator Fritz voting YES by proxy.

Discussion:

Senator Towe explained amendments (hb062224.asf). He said that Section 6 was stricken to coincide with the previous amendments.

Senator Bartlett said HB 622 prohibited lump sum payments on rehabilitation, and added that the amendment would allow lump sum on rehabilitation benefits.

Senator Towe said that this would return the language to the status quo.

Senator Bartlett read the section 39-71-741 MCA as unamended. She said the amendment would specify that rehabilitation benefits would not be subject to the lump sum provisions of 39-71-741, MCA.

Motion:

Senator Bartlett moved HB 622 be amended (hb062224.asf).

Discussion:

Senator Aklestad asked about the amendment to the Title, page 1, lines 8 and 9. Susan Fox said that this returned the law to the status quo. She read the title with the amendment.

Senator Towe clarified the amendment brought the Bill back to status quo.

Senator Keating asked if what the amendment said was that under the current statutes rehabilitation benefits were not subject to lump sum agreements. Senator Towe said they were subject to lump sum agreements.

Senator Keating asked if it was not good to lump sum medical benefits why it was good to lump sum rehabilitation benefits. Senator Towe answered that his understanding was that the amendment would return the law to status quo. He said he thought there was a two-year limitation on this. He asked Chuck Hunter, from DOLI to address this issue.

Senator Harp said the limitation was defined, and it was up to two years. He said there was a distinction between lump sums on medical and rehabilitation benefits.

Chuck Hunter, Montana Department of Labor and Industry (DOLI) told the Committee that currently medical benefits could be lump summed. HB 622 was written in such a manner that would prevent rehabilitation benefits from being lump summed. The amendment would return it to the status quo in which rehabilitation benefits can be lump summed.

Senator Keating asked if medical benefits could be paid in a lump sum. Senator Harp said that had been amended out of HB 622.

Senator Hockett asked Mr. Hunter what the rational was for lump

summing rehabilitation benefits. Mr. Hunter answered that there could be a number of rationales for lump summing rehabilitation benefits, including that there may be some dispute over the compensability of the claim. He said settling everything in a lump would be a way that the insurer and the worker could agree that this would take care of the settlement. He said that if a worker wished to established a business agreement with the insurer, and the benefits may better be paid in a lump sum to enable the worker to establish a business.

Senator Hockett said that he had worked with many people in vocational rehabilitation programs and had found an incentive when the person had been kept in the program. He said he would like to remove the incentive of these people to drop out of the rehabilitation programs. He said if a person had the money in pocket, the worker may drop out of the rehabilitation.

Senator Lynch said he supported the amendment because he had seen people under rehabilitation that should not have been there. He stated rehabilitation could force a man with a bad back, in his late fifties, to learn to become a receptionist secretary. The man, if he completes the entire vo-tech rehabilitation education would not become a receptionist secretary. He said it was better to lump sum and see if there was a program that could better benefit the worker, rather than forcing the worker into a position where there would be no benefit received.

Senator Bartlett said she moved the amendment not because she thought workers should automatically lump sum their rehabilitation benefits, nor did she think that they would. She continued, saying there were instances in which lump summing could keep a case out of court, because being able to negotiate a settlement on rehabilitation is what would settle the claim. If that possibility is removed, court action may be the result. The option that the insurer and the claimant could negotiate together with departmental review may keep such rehabilitation cases out of court.

Vote:

The motion FAILED by a roll call vote, with Senators Forrester, Keating, Harp, Hertel, Aklestad, and Burnett voting NO. Senators Hockett, Wilson, Towe, Fritz, Bartlett, and Lynch voted YES.

Discussion:

The amendments (HB062223.ASF) were discussed. Senator Towe told the Committee that on page 27, HB 622 created a new concept of temporary partial disability, and the theory was that this would encourage a worker to return to work sooner if there was some partial disability even if the worker could not do the full job. He said there were comments that HB 622 should in no event allow the worker to receive more workers' compensation benefits than they would receive if the worker received temporary total

disability; and the worker should not receive a total of more than 66⅔ of his previous pay. He said that the amendment would select the former, spelling out that the worker could not receive funding in excess of what the worker would be entitled to under total disability, but would not limit the worker to two thirds. He said this amendment took out weekly compensation benefits, and said it helped to make the Bill read more smoothly.

Senator Harp said everything that the benefit schedule was on was whatever the basic benefits were of 66 ⅔ of the average weekly wage earned at the time of injury. He said this had been the driving force of benefits, but the amendment diverged from that. He asked if under this proposed amendment would the worker exceed the benefits that the worker would be entitled to under temporary total disability.

Senator Towe answered the purpose of the amendment would be to limit the benefits so the worker would not receive any more benefits then what would be received under temporary total disability. He asked if there was an incentive, why not give the worker the right to keep the money that the worker could earn, and why limit it to two thirds.

Susan Fox explained Nancy Butler, General Council from the State Fund, had worked out scenarios. Senator Towe recognized Nancy Butler, and asked her to explain.

Nancy Butler told the Committee that if a person was making $7.00 per hour, and went back to work at minimum wage, doing a modified job, the difference would be between $280 per week and $170 per week, or $110 per week discrepancy. She explained as HB 622 currently read, the worker would be entitled to the difference from the insurer as long as it did not exceed the state's average weekly wage, or $349 per week. She said the $110 difference would be paid by the insurer, and this would raise the worker's benefits to the regular $7.00 per hour. She said if the employer earned $15.00 per hour, or $600 per week, and was put back on a modified job, being paid minimum wage, or $170 per week, with the difference being $430, the difference would be greatly different, but the employer would be limited to the state's average weekly wage, and be reimbursed $349 per week. She said if 66 ⅔ of the difference between the wage and what the worker was earning on temporary partial disability was added into HB 622, then this would limit it to be two thirds of the difference, and would be less then the temporary total rate, if the difference were the $110. The difference in the second scenario was $430, two thirds of this being $280. This exceeds the state's weekly average wage.

Senator Harp said the problem was that the upper income wage earners would be affected most by this provision.

Senator Towe said the proposal on hand was not the two thirds, but that the benefits be limited to the total disability rate.

He asked Nancy Butler to explain the scenarios under this law.

Ms. Butler explained that the person making $280 per week, with the $110 difference being less than the temporary total rate (two thirds of $280), would not be affected, as the whole $110 would be paid in benefits. The person making $600 per week, would have a temporary total disability of higher then $349, and thus would be receiving only the $349, Montana's average weekly wage, rather than the temporary total disability.

Senator Towe said if the person was making $600 per week before injury, and goes back to partial work on minimum wage, the person would be limited to a total temporary rate of $349. If the two thirds route was taken, this worker would be limited to about $280. In this example, the amendment would allow for the higher benefits.

Senator Harp argued against the amendment, stating he was not happy with the state's average weekly wage at the time of injury, and said he understood and was happy with the 66 ⅔ that was in HB 622.

Motion:

Senator Lynch moved HB 622 be amended (HB062223.ASF).

Discussion:

Senator Keating asked if the weekly compensation benefits for temporary partial disability must be 66 ⅔ of the difference between the wage earned before, and the wage earned after injury.

Senator Towe said the motion was to limit the benefit, so the benefits could never be higher than the temporary total disability benefits.

Vote:

The Motion to amend HB 622 (HB062223.ASF) CARRIED by a roll call vote, with Senators Lynch, Towe, Bartlett, Fritz, Wilson, Hockett, and Forrester voting YES. Senators Harp, Aklestad, Keating, Hertel, and Burnett, voted NO.

Discussion:

Senator Towe explained the amendments (hb062221.asf). He told the Committee that in Section 26, two or more employers could join together and perhaps get a better rate. He said there may be a technical problem on page 50, line 15 "groups certified under this section may purchase individual workers' compensation policies covering each member of the group from any insurer authorized to write workers' compensation insurance in this state". Senator Towe said after the word "state", the wording " except that the State Fund, as defined in 39-71-2312, has the

right to refuse coverage of a group and its plan of operation but cannot refuse coverage to an individual employer". He said this would allow the State Fund to deny coverage for the group. Senator Towe said the amendment would not allow the State Fund to refuse coverage to any individual employer. The State Fund could except an individual employer out of a group.

Senator Bartlett said this was not how she read the amendment. She told the Committee the amendment simply said the State Fund had the right to refuse coverage to a group. She said an employer could not be segregated from the group.

Senator Towe said Senator Bartlett was technically correct in that the State Fund could refuse the whole group and make it reorganize.

Motion:

Senator Wilson moved HB 622 be amended (hb062221.asf).

Discussion:

Senator Aklestad asked why this amendment was needed.

Mike Micone, Montana Motor Carriers Association (MMCA), told the Committee he did not know why a group would be refused, but the financial condition as a group may be such that the State Fund may not wish to risk providing coverage.

Jim Murphy, State Fund, said the group program in HB 622 called for the insurer to pay a premium volume discount. He said if the group was involved in something, such as a safety program, the State Fund would like to review the program before granting the premium volume discount.

Senator Aklestad said there was no incentive for the State Fund to insure a group, and they had to give a discount. He said there would be no incentive for the State Fund to accept any groups, because it would get higher premiums under the individual employers.

Mr. Murphy responded that the incentive would be similar as current incentives. The State Fund provides discounts to groups of employers providing State Fund controlled safety programs, so the incentive would be that if a group initiated a good safety program, and reduce the accidents, there would be less cost to the State Fund.

Mike Micone told the Committee MMCA had believed it was discretionary for the State Fund to authorize a group. The State Fund did not read HB 622 this way, and thus the clarification amendment was offered.

Vote:

The motion that HB 622 be amended (hb062221.asf) CARRIED UNANIMOUSLY.

Motion:

Senator Lynch moved HB 622 be amended (hb062226.asf).

Discussion:

Senator Towe said amendment (hb062226.asf) would remove the apportionment provided for in HB 622. He told the Committee HB 622 without this amendment says that if a worker is previously injured and received workers' compensation, and then is injured a second time, and receive workers' compensation, an amount is figured on how much should be paid on the current injury by the previous carrier, and how much should be paid by the current carrier. This amount is apportioned out. Senator Towe noted that under current law, this is not allowed to happen, and the previous carrier is not liable for any of the new claim, and the new carrier takes all the new responsibility. Senator Towe expressed the problem with apportionment is that it is very difficult to manage. He said medical panels would cost too much, and it would be hard to find enough doctors to go through all the apportionment.

Senator Harp spoke in favor of apportionment as a way of holding costs down for an employer that has an employee that had a previous injury. The employer would be assessed on the new injury, though the previous injury may have had nothing to do with the employer, but had something to do with the new injury. He said there were potential litigation problems with apportionment, and the language may not be perfect in HB 622, but the concept was a valid one. He said he opposed the amendment.

Vote:

The motion to amend HB 622 (hb062226.asf) FAILED by a roll call vote with Senators Hertel, Hockett, Burnett, Harp, Fritz, Bartlett, Keating, and Aklestad voting NO. Senators Towe, Lynch, Wilson, and Forrester voted YES.

Discussion:

The amendments (hb062220.asf) were discussed. Senator Towe explained one issue he wanted to discuss, in terms of an amendment to HB 622, was that of the use of alcohol during working hours. In HB 361, the employee was not eligible for benefits if the employee's use of alcohol or drugs not prescribed by a physician is the sole and exclusive cause of the death or injury. He said the language in HB 361 changed "sole and exclusive" to "major contributing", and defined "major contributing" as the cause that is the leading factor

contributing to the result in comparison to all other contributing causes.

Senator Towe also said "wage" in HB 361 would have included income or payment in the form of a draw, wage, net profit, or substitute for money received, or taken by sole proprietor or partner, regardless of whether the sole proprietor or partner has performed work or provided services for that enumeration. He said this would be a more broad, comprehensive definition of wage which would then govern the premium paid and the benefits received.

Senator Harp asked if "major contributing" was a more defined degree than "sole and exclusive". Senator Towe answered "major contributing" was a less precise term, but under the circumstances acceptable, because it was defined.

Senator Lynch asked if the amendment was changing present law from "sole and exclusive" to "major contributing". Senator Towe answered this was the first part of the amendment. He noted that the broader definition of "wage" was also in the amendment.

Senator Lynch asked these amendments be divided.

Senator Keating said the amendment would strike Section 24 in its entirety. He argued the vote on the last amendment was to retain this section. Susan Fox said this was correct, and that this would have to be coordinated between the two.

Senator Towe suggested on page 52, lines 13 and 14, strike the wording "sole and exclusive", insert "major contributing", renumber by adding (6), and renumber subsequent sections.

Motion\Vote:

Senator Fritz moved to amend HB 622 by striking "sole and exclusive" and inserting "major contributing" on page 52, lines 13 and 14. The Motion FAILED by a roll call vote with Senators Forrester, Lynch, Keating, Aklestad, Harp, Hertel, Burnett, and Wilson voting NO. Senators Towe, Bartlett, Fritz, and Hockett voted YES.

Motion:

Senator Aklestad moved HB 622 BE CONCURRED IN AS AMENDED.

Discussion:

Senator Lynch spoke against the motion. He said HB 622 was too confusing, and should be killed.

Senator Harp defended HB 622, saying that though HB 622 was confusing, there had not been fair time given to it during

committee hearings and action. He said 11 amendments were offered in the House Select Committee on Workers' Compensation, and there had been some amendments just offered. He said if HB 622 could get to a conference committee as quickly as possible, time could be spent to clean the Bill up, and help iron out the wrinkles in it. He stated there were problems with the apportionment section, and added that the section was not totally understood. He asked to keep HB 622 alive because it offered the use of the Taft-Hartly Act for the pension for organized labor, the ability to potentially work together on workers' compensation, the fraud sections, and the new benefits allowed to get people back to work, all sections worth looking at. He reiterated that HB 622 had not had the proper time spent on it in any committee.

Senator Lynch said his fear was that HB 622 was so complicated that it could not be explained in a presentation on the Floors of either the Senate or the House. He urged that HB 622 be killed, and for the issue to come up again next session with more time to work through it.

Senator Towe said he agreed with Senator Harp that there were good items in HB 622 that should not die. He said the temporary partial was an incentive for people to return to work, and it should not have to wait for two years until the next session to be addressed. He said the group plan was an issue with genuine potential for helping out the situation.

Vote:

The Motion that HB 622 BE CONCURRED IN AS AMENDED CARRIED by a roll call vote, with Senators Hockett, Harp, Towe, Forrester, Aklestad, Burnett, Bartlett, Fritz, and Keating voting YES. Senators Wilson, Lynch, and Hertel voted NO. Senator Towe was assigned to carry HB 622.

EXECUTIVE ACTION ON HB 504

Discussion:

Senator Towe explained HB 504 would fund the old fund liability, putting a 0.5 percent payroll tax on employers and employees. He offered an amendment (hb050405.asf) Senator Towe said his proposal was a bond issue that would authorize a bonding that would be necessary to settle the entire old fund problem. The bond could be sold on a 20 year basis, and would require payment of 0.5 percent by the employer, but nothing by the employee. He said the amendment would solve the issue of employee contribution. Senator Towe handed out sheets of figures (Exhibits #2 and #3). Senator Towe explained Exhibit #2. He said the first column showed the estimated payroll base; the second column showed the current payroll tax, at 0.28 percent;

ROLL CALL

SENATE SELECT COMMITTEE ON Workers' Compensation **DATE** 04/06/93

NAME	PRESENT	ABSENT	EXCUSED
Senator Towe	X		
Senator Forrester	X		
Senator Bartlett	X		
Senator Wilson	X		
Senator Burnett	X		
Senator Lynch	X		
Senator Aklestad	X		
Senator Fritz	X		
Senator Hockett	X		
Senator Hertel	X		
Senator Harp	X		
Senator Keating	X		

Attach to each day's minutes

SENATE SELECT COMMITTEE REPORT

April 7, 1993

MR. PRESIDENT:
We, your select committee on Worker's Compensation having had under consideration House Bill No. 622 (third reading copy -- blue), respectfully report that House Bill No. 622 be amended as follows and as so amended be concurred in.

Signed: Thomas E. Towe
Senator Thomas E. "Tom" Towe, Chair

That such amendments read:

1. Title, page 1, lines 7 and 8.
Following: "APPOINTMENTS;" on line 7
Strike: the remainder of line 7 through "BENEFITS;" on line 8

2. Title, page 2, line 12.
Strike: "39-71-741,"

3. Page 2, line 19.
Strike: "23"
Insert: "22"

4. Page 15, line 22 through page 19, line 11.
Strike: section 5 in its entirety
Renumber: subsequent sections

5. Page 27, line 12.
Following: "(2)"
Strike: line 12 through "benefits"
Insert: "An insurer's liability"

6. Page 27, line 18.
Strike: line 18 in its entirety
Insert: "the injured worker's temporary total disability benefit rate."

7. Page 49, line 11.
Strike: "23"
Insert: "22"

8. Page 50, line 15.
Following: "STATE"
Insert: ", except that the state fund, as defined in 39-71-2312, has the right to refuse coverage of a group and its plan of operation but cannot refuse coverage to an individual employer"

Amd. Coord.
Sec. of Senate

Sen. Towe
Senator Carrying Bill

781556SC.San

9. Page 55, line 24.
Page 56, line 2.
Strike: "8"
Insert: "7"

10. Page 56, lines 3 and 6.
Strike: "10"
Insert: "9"

11. Page 56, lines 7 and 10.
Following: "~~20~~"
Insert: "17 and"
Following: "18"
Strike: "AND 19"

12. Page 56, lines 11 and 13.
Following: "SECTIONS"
Insert: "21 and"
Following: "22"
Strike: "AND 23"

-END-

ROLL CALL VOTE

SENATE SELECT COMMITTEE Workers' Compensation **BILL NO.** HB 622

DATE 4/6/93 **TIME** 4:02 **A.M.** **P.M.**

NAME	YES	NO
Senator Harp		X
Senator Towe	X	
Senator Fritz	X	
Senator Wilson	X	
Senator Lynch	X	
Senator Hockett		X
Senator Burnett		X
Senator Aklestad		X
Senator Bartlett	X	
Senator Hertel		X
Senator Forrester		X
Senator Keating		X

KELSEY CHAPMAN
SECRETARY

SENATOR TOM TOWE
CHAIR

MOTION: By Sen. Towe to amend HB 622 (~~hb062222.asf~~) (hb062225.asf.)

ROLL CALL VOTE

SENATE SELECT COMMITTEE Workers' Compensation BILL NO. HB 622

DATE 4/6/93 TIME 4:25 A.M. (P.M.)

NAME	YES	NO
Senator Towe	X	
Senator Wilson	X	
Senator Forrester		X
Senator Keating		X
Senator Harp		X
Senator Hockett	X	
Senator Hertel		X
Senator Fritz	X	
Senator Bartlett	X	
Senator Aklestad		X
Senator Burnett		X
Senator Lynch	X	

KELSEY CHAPMAN
SECRETARY

SENATOR TOM TOWE
CHAIR

MOTION: By Sen. Bartlett that HB622 be amended (hb062224.asf). FAILED

ROLL CALL VOTE

SENATE SELECT COMMITTEE Workers' Compensation BILL NO. HB 622

DATE 4/6/93 TIME 4:37 A.M. (P.M.)

NAME	YES	NO
Senator Lynch	X	
Senator Harp		X
Senator Aklestad		X
Senator Keating		X
Senator Towe	X	
Senator Bartlett	X	
Senator Fritz	X	
Senator Hockett	X	
Senator Hertel		X
Senator Burnett		X
Senator Wilson	X	
Senator Forrester	X	

KELSEY CHAPMAN
SECRETARY

SENATOR TOM TOWE
CHAIR

MOTION: By Sen. Lynch that HB 622 be amended (HB062223.AGF).

ROLL CALL VOTE

SENATE SELECT COMMITTEE Workers' Compensation **BILL NO.** HB 622

DATE 4/6/93 **TIME** 4:55 **A.M.** (P.M.)

NAME	YES	NO
Senator Hertel		X
Senator Hockett		X
Senator Burnett		X
Senator Harp		X
Senator Fritz		X
Senator Bartlett		X
Senator Wilson	X	
Senator Lynch	X	
Senator Keating		X
Senator Aklestad		X
Senator Towe	X	
Senator Forrester	X	

KELSEY CHAPMAN
SECRETARY

SENATOR TOM TOWE
CHAIR

MOTION: By Sen. Lynch that HB622 be amended (hb062226.asf)

ROLL CALL VOTE

SENATE SELECT COMMITTEE Workers' Compensation BILL NO. HB 622

DATE 4/6/93 TIME 5:03 A.M. P.M.

NAME	YES	NO
Senator Forrester		X
Senator Lynch		X
Senator Bartlett	X	
Senator Towe	X	
Senator Keating		X
Senator Aklestad		X
Senator Harp		X
Senator Hertel		X
Senator Hockett	X	
Senator Burnett		X
Senator Fritz	X	
Senator Wilson		X

KELSEY CHAPMAN
SECRETARY

SENATOR TOM TOWE
CHAIR

MOTION: By Sen. Fritz that HB 622 be amended.

ROLL CALL VOTE

SENATE SELECT COMMITTEE Workers' Compensation BILL NO. HB 622

DATE 4/6/93 TIME 5:05 A.M. (P.M.)

NAME	YES	NO
Senator Hockett	X	
Senator Harp	X	
Senator Towe	X	
Senator Forrester	X	
Senator Lynch		X
Senator Wilson		X
Senator Hertel		X
Senator Aklestad	X	
Senator Burnett	X	
Senator Fritz	X	
Senator Bartlett	X	
Senator Keating	X	

KELSEY CHAPMAN
SECRETARY

SENATOR TOM TOWE
CHAIR

MOTION: By Sen. Aklestad that HB 622 BE CONCURRED IN AS AMENDED.

Amendments to House Bill No. 622
Third Reading Copy

Requested by Senator Towe
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
April 6, 1993

1. Page 15, lines 20 and 21.
Following: "worker" on line 20
Strike: the remainder of line 20 through "benefits" on line 21
Insert: "is presumed to have been released on the day that the worker failed to keep the medical appointment"

Amendments to House Bill No. 622
Third Reading Copy

For the Committee on Workers' Compensation

Prepared by Susan B. Fox
April 6, 1993

1. Title, page 1, lines 7 and 8.
Following: "APPOINTMENTS;" on line 7
Strike: the remainder of line 7 through "BENEFITS;" on line 8

2. Title, page 2, line 12.
Strike: "39-71-741,"

3. Page 2, line 19.
Strike: "23"
Insert: "22"

4. Page 15, line 22 through page 19, line 11.
Strike: section 5 in its entirety
Renumber: subsequent sections

5. Page 27, line 12.
Following: "(2)"
Strike: line 12 through "benefits"
Insert: "An insurer's liability"

6. Page 27, line 18.
Strike: line 18 in its entirety
Insert: "the injured worker's temporary total disability benefit rate."

7. Page 49, line 11.
Strike: "23"
Insert: "22"

8. Page 50, line 15.
Following: "STATE"
Insert: ", except that the state fund, as defined in 39-71-2312, has the right to refuse coverage of a group and its plan of operation but cannot refuse coverage to an individual employer"

9. Page 55, line 24.
Page 56, line 2.
Strike: "8"
Insert: "7"

10. Page 56, lines 3 and 6.
Strike: "10"
Insert: "9"

11. Page 56, lines 7 and 10.
Following: "~~20~~"

Insert: "17 and"
Following: "18"
Strike: "AND 19"

12. Page 56, lines 11 and 13.
Following: "SECTIONS"
Insert: "21 and"
Following: "22"
Strike: "AND 23"

Amendments to House Bill No. 622
Third Reading Copy

Requested by Sen. Towe
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
April 6, 1993

1. Title, page 1, lines 8 and 9.
Following: "BENEFITS;" on line 8
Strike: the remainder of line 8 through "REQUIREMENTS;" on line 9

2. Title, page 2, line 12.
Strike: "39-71-2001"

3. Page 2, line 19.
Strike: "23"
Insert: "22"

4. Page 19, line 12 through page 22, line 6.
Strike: section 6 in its entirety
Renumber: subsequent sections

5. Page 49, line 11.
Strike: "23"
Insert: "22"

6. Page 55, line 24.
Page 56, line 2.
Strike: "8"
Insert: "7"

7. Page 56, lines 3 and 6.
Strike: "10"
Insert: "9"

8. Page 56, lines 7 and 10.
Following: "~~20~~"
Insert: "17 and"
Following: "18"
Strike: "AND 19"

9. Page 56, lines 11 and 13.
Following: "SECTIONS"
Insert: "21 and"
Following: "22"
Strike: "AND 23"

Amendments to House Bill No. 622
Third Reading Copy

Requested by Sen. Towe
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
April 6, 1993

1. Page 27, line 12.
Following: "(2)"
Strike: line 12 through "benefits"
Insert: "An insurer's liability"

2. Page 27, line 18.
Strike: line 18 in its entirety
Insert: "the injured worker's temporary total disability benefit rate."

Amendments to House Bill No. 622
Third Reading Copy

Requested by Sen. Towe
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
April 6, 1993

1. Page 50, line 15.
Following: "STATE"
Insert: ", except that the state fund, as defined in 39-71-2312, has the right to refuse coverage of a group and its plan of operation but cannot refuse coverage to an individual employer"

Amendments to House Bill No. 622
Third Reading Copy

Requested by Senator Towe
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
April 6, 1993

1. Title, page 1, lines 12 and 13.
Following: "INFIRMITY;"
Strike: the remainder of line 12 and line 13 in their entirety

2. Title, page 2, line 11.
Strike: "39-71-407,"

3. Title, page 2, line 13.
Following: "~~AND~~"
Insert: "AND"
Strike: "39-72-706, AND 39-72-707,"

4. Page 51, line 6 through page 54, line 23.
Strike: sections 24, 25, and 26 in their entirety
Renumber: subsequent sections

no motion

Amendments to House Bill No. 622
Third Reading Copy

Requested by Sen. Towe
For the Committee on Workers' Compensation

Prepared by Susan B. Fox
April 6, 1993

1. Title, page 2, line 10.
Following: "39-71-116,"
Insert: "39-71-123,"

2. Page 51, line 6 through page 53, line 12.
Strike: Section 24 in its entirety
Insert: **"Section 24.** Section 39-71-407, MCA, is amended to read:

"39-71-407. Liability of insurers -- limitations. (1) Every insurer is liable for the payment of compensation, in the manner and to the extent ~~hereinafter~~ provided in this section, to an employee of an employer that it insures who receives an injury arising out of and in the course of ~~his~~ employment or, in the case of ~~his~~ death from ~~such~~ the injury, to ~~his~~ the employee's beneficiaries, if any.

(2) (a) An insurer is liable for an injury as defined in 39-71-119 if the claimant establishes that it is more probable than not that:

(i) a claimed injury has occurred; or

(ii) a claimed injury aggravated a preexisting condition.

(b) Proof that it was medically possible that a claimed injury occurred or that ~~such~~ the claimed injury aggravated a preexisting condition is not sufficient to establish liability.

(3) An employee who suffers an injury or dies while traveling is not covered by this chapter unless:

(a) (i) the employer furnishes the transportation or the employee receives reimbursement from the employer for costs of travel, gas, oil, or lodging as a part of the employee's benefits or employment agreement; and

(ii) the travel is necessitated by and on behalf of the employer as an integral part or condition of the employment; or

(b) the travel is required by the employer as part of the employee's job duties.

(4) An employee is not eligible for benefits otherwise payable under this chapter if the employee's use of alcohol or drugs not prescribed by a physician is the ~~sole and exclusive~~ major contributing cause of the injury or death. However, if the employer had knowledge of and failed to attempt to stop the employee's use of alcohol or drugs, this subsection does not apply.

(5) If a claimant who has reached maximum healing suffers a subsequent nonwork-related injury to the same part of the body, the workers' compensation insurer is not liable for any compensation or medical benefits caused by the subsequent nonwork-related injury.

(6) As used in this section, "major contributing cause" means a leading factor contributing to the result when compared to all other contributing factors.""

3. Page 55, line 18.
Following: line 17
Insert: "Section 28. Section 39-71-123, MCA, is amended to read:
"39-71-123. Wages defined. (1) "Wages" means the gross remuneration paid in money, or in a substitute for money, for services rendered by an employee, or income provided for in subsection (1)(d). Wages include but are not limited to:
(a) commissions, bonuses, and remuneration at the regular hourly rate for overtime work, holidays, vacations, and sickness periods;
(b) board, lodging, rent, or housing if it constitutes a part of the employee's remuneration and is based on its actual value; ~~and~~
(c) payments made to an employee on any basis other than time worked, including but not limited to piecework, an incentive plan, or profit-sharing arrangement~~.~~; and
(d) income or payment in the form of a draw, wage, net profit, or substitute for money received or taken by a sole proprietor or partner, regardless of whether the sole proprietor or partner has performed work or provided services for that remuneration.
(2) Wages do not include:
(a) employee expense reimbursements or allowances for meals, lodging, travel, subsistence, and other expenses, as set forth in department rules;
(b) special rewards for individual invention or discovery;
(c) tips and other gratuities received by the employee in excess of those documented to the employer for tax purposes;
(d) contributions made by the employer to a group insurance or pension plan; or
(e) vacation or sick leave benefits accrued but not paid.
(3) For compensation benefit purposes, the average actual earnings for the four pay periods immediately preceding the injury are the employee's wages, except if:
(a) the term of employment for the same employer is less than four pay periods, in which case the employee's wages are the hourly rate times the number of hours in a week for which the employee was hired to work; or
(b) for good cause shown by the claimant, the use of the four pay periods does not accurately reflect the claimant's employment history with the employer, in which case the insurer may use additional pay periods.
(4) (a) For the purpose of calculating compensation benefits for an employee working concurrent employments, the average actual wages must be calculated as provided in subsection (3).
(b) The compensation benefits for a covered volunteer must be based on the average actual wages in ~~his~~ the volunteer's regular employment, except self-employment as a sole proprietor or partner who elected not to be covered, from which ~~he~~ the volunteer is disabled by the injury incurred.

(c) The compensation benefits for an employee working at two or more concurrent remunerated employments must be based on the aggregate of average actual wages of all employments, except self-employment as a sole proprietor or partner who elected not to be covered, from which the employee is disabled by the injury incurred.

(5) The compensation benefits and the payroll, for premium purposes, for a volunteer firefighter covered pursuant to 39-71-118(4) must be based upon a wage of not less than $900 a month and not more than 1½ times the average weekly wage as defined in this chapter.""

Renumber: subsequent sections